

## Social Service Needs

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

**ARE YOU HAVING DIFFICULTIES OR PROBLEMS WITH:**

(Please check the appropriate box.)

	None	Mild	Moderate	Severe
1. Finances				
2. Transportation				
3. Personal Stress (feeling worried, sad, angry, frustrated, difficulty sleeping)				
4. Activities of Daily Living (personal tasks, such as dressing, bathing, walking, toileting)				
5. Household tasks (laundry, housekeeping, meals, shopping for for household needs)				
6. Housing (repairs, need to find housing)				
7. Employment or Career Issues				
8. Health / Nutrition (need help finding a doctor, health services, or following a diet)				
9. Obtaining nursing home placement or assisted living				
10. Feeling isolated (spending too much time alone)				
11. Family Problems				
12. Parenting or Caregiver concerns				
13. Other: (please explain briefly)				

**Would like a Social Work consultation?\* YES or NO**

**\*During this consultation you would meet with a licensed social worker who would find community resources that would assist you in resolving your current needs. This consultation is provided by St. Louis Physical Therapy at no cost to you.**