Provider Questionnaire

Client Name: _____

Contact Name: _____ Phone #: _____

Type of Provider: _____

1.	What services are provided to the client? *(or attach a copy of Plan of Care)*	
2.	How often did client accept services?	
3.	Did client often refuse services? If so, how often?	
4.	Were services adequate for client? If not what services or amounts of services do you think client needs?	
5.	What are the conditions of client's living space?	
6.	Does client have any issues with verbal aggression? If yes, what are the triggers?	
7.	How often does client display verbal aggression? (rarely, daily, etc.)	
8.	What are some coping mechanisms that client uses to control displays of verbal aggression?	
9.	What types of de-escalation have staff found helpful in working with client during client's verbal aggression?	
10.	Is client able to manage their own finances? ☐ Yes / ☐ No	
11.	Has there been issues with client not having money to buy groceries and personal need items? ☐ Yes / ☐ No	
13.	Has client had difficulties paying bills, rent? If so how often does issues with non-payment or late payments occur?	
14.	How many med refusals does client have within the last 3 months?	
15.	How many appointment cancellations has the client had within the last 3 months?	
16.	Has there been any instances of property destruction that the client has caused? If yes what were the circumstances?	
17.	Has client had a VA report against them for maltreatment of another client or child? ☐ Yes / ☐ No	
18.	Does client have substance use concerns? ☐ Yes / ☐ No If yes, what are the concerns?	
19.	How has client been active in independently maintaining stability with sobriety? ☐ Yes / ☐ No	
20.	What is their individual abuse prevention plan?	