

# Client Feedback Form

**Date of Review:**

Client Name:

Phone:

Mailing Address:

Discharge Date:

Date of 1st Contact:

Employment

Housing

Are you drug and/or alcohol free? If no, when was your date of last use?

Aftercare Compliance

- Counseling
- Self-help meetings
- Referrals needed? Please specify below

**Overall Impression of Experience:**

**Additional Comments:**

**Signature:**