



Please Indicate One: \_\_\_Employee Assistance Program
\_\_\_Student Assistance Program

Section I: Client Identifying Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

You Are the: Employee \_\_\_\_\_ Spouse \_\_\_\_\_ Dependent \_\_\_ Student \_\_\_\_\_ Significant Other \_\_\_\_\_

Relationship Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Gender: M \_\_\_ F \_\_\_

EMPLOYEE ASSISTANCE
FILL OUT THIS PORTION:

Education: \_\_\_\_\_ Grade/Degree \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Shift: Days \_\_\_\_\_ Evenings \_\_\_ Nights \_\_\_ PRN \_\_\_\_\_

Supervisor: \_\_\_\_\_ Supervisor's Phone: \_\_\_\_\_

Is this visit mandated by your supervisor? [ ] Yes [ ] No If your answer is yes please check the following:

Current Level of Disciplinary Action:

- [ ] First Level: Documented Verbal Warning [ ] Third Level: Written Corrective Action
[ ] Second Level: Written Corrective Action [ ] Fourth Level: Discharge

Any previous disciplinary action [ ] Yes [ ] No

Explain if answer is yes: \_\_\_\_\_

STUDENT ASSISTANCE
FILL OUT THIS PORTION:

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Is this referral mandatory? \_\_\_ Yes \_\_\_ No

If yes, who referred you? \_\_\_\_\_ For what reason? \_\_\_\_\_

PLEASE COMPLETE THIS SECTION

Section II: Mental Health History

Have you been seen in counseling/therapy in the past? \_\_\_ Yes \_\_\_ No

If yes, by whom? \_\_\_\_\_ Dates: \_\_\_\_\_

Have you been seen by a psychiatrist in the past? \_\_\_ Yes \_\_\_ No

If yes, by whom? \_\_\_\_\_ Dates: \_\_\_\_\_

Please check any of the items that currently apply:

- [ ] Academic Difficulties [ ] Fatigue [ ] Seizures
[ ] Angry Outbursts/Irritability [ ] Helplessness [ ] Sleep Disturbance
[ ] Confusion/problems with concentration [ ] Hopelessness [ ] Social/behavioral difficulty at school
[ ] Crying spells [ ] Increased conflict with family/friends/co-workers [ ] Thoughts of hurting self
[ ] Difficulty at work [ ] Mood swings [ ] Thoughts of hurting others
[ ] Excessive sweating [ ] Problems with memory [ ] Weight gain or loss

**Medications:** Please list **all** medications you are now taking or have taken in the past three months.

Medication                      Dosage                      M.D. Prescribing                      Duration                      Helpful (Y/N)

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**Section III: Medical History**

Primary Care Physician: \_\_\_\_\_ Specialty Physician: \_\_\_\_\_

Please list any significant illness, hospitalizations, injuries, treatments:

**Date                      Problem and Treatment**

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Please check any of the items that currently apply:

- |                                             |                                        |                                           |
|---------------------------------------------|----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Tremors/Shaking  |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Hot Flashes   | <input type="checkbox"/> Vomiting         |
| <input type="checkbox"/> Fainting Spells    | <input type="checkbox"/> Numbness      | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Physical Pain |                                           |

**Section IV: Substances Used**

Amount of caffeinated beverages per day: coffee \_\_\_\_\_ soda \_\_\_\_\_ tea \_\_\_\_\_

Number of cigarettes smoked per day: \_\_\_\_\_ Are you interested in information regarding quitting? Y/N

How often do you use mood altering drugs per week? \_\_\_\_\_ Alcohol Use: Y/N Last Use: \_\_\_\_\_

**Section V: Description of Presenting Problem**

Check all areas that currently apply:

- |                                                          |                                          |                                                |                                       |
|----------------------------------------------------------|------------------------------------------|------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Anger                           | <input type="checkbox"/> Drug/Alcohol    | <input type="checkbox"/> Job Performance       | <input type="checkbox"/> Stress       |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Legal                 | <input type="checkbox"/> Verbal Abuse |
| <input type="checkbox"/> Communication/<br>Relationships | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Marital/Relationships | <input type="checkbox"/> Other        |
| <input type="checkbox"/> Crisis                          | <input type="checkbox"/> Family          | <input type="checkbox"/> Physical Health       |                                       |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Financial       | <input type="checkbox"/> School Performance    |                                       |
| <input type="checkbox"/> Domestic Violence               | <input type="checkbox"/> Gambling        | <input type="checkbox"/> Sexual Abuse          |                                       |
|                                                          | <input type="checkbox"/> Internet Use    | <input type="checkbox"/> Sexuality             |                                       |

Please state why you decided to come to the EAP:

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How long has this been an issue for you? \_\_\_\_\_

How would you estimate the severity of the problem? Mild Moderate Serious Severe

How would you rate your current level of productivity on a scale of 1-100 with 1 being least productive and 100 being most productive? \_\_\_\_\_

Rate your current emotional well-being:

1. Excellent    2. Very Good    3. Good    4. Fair    5. Poor? \_\_\_\_\_

In the past, what has been helpful to you in dealing with this problem? \_\_\_\_\_

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**Section VI: Family Information**

Are your parents living?  Yes  No

Are your parents divorced?  Yes  No How old were you when they divorced? \_\_\_\_\_

Do you have brothers and/or sisters?

Brothers	Ages	Sisters	Ages

Have any members of your family had problems with:

Drugs  Alcohol  Depression  Anxiety  Other Mental Health Problems

Specifically who?

Problem	Who	Current Y/N	Past Y/N

**With whom do you live?**

Name	Age	Relationship to You	Supportive? Y/N

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**In the event of a cancellation – please provide a phone number where you can be reached:**

**Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Pager** \_\_\_\_\_

Are there any other instructions for us?

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