St. Elizabeth
Employee Assistance Program

Assessment - Adult Report

Date of Birth: _____ Age: _____

Client Name:_____
Chart No. _____
Date: _____

1. Why have you come to EAP (Presenting issue for Client)?

_____

_____

_____

2. How long has this been an issue?

_____

3. What have you tried to do to resolve this issue?

_____

_____

4. What are your goals for counseling?

_____

_____

_____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems and chemical dependency/use.)

_____

_____

_____

_____

6. Has any member of your family, including grandparents, been diagnosed or had significant problems with mental health issues, alcohol use or chemical dependency? If so, please explain

_____

_____

Client name: _____
Chart number: _____
Date: _____

7. Who resides with you in your home.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Health (describe your general health as well as any chronic conditions including pain)

_____

_____

_____

When was your last complete physical exam by an M.D._____

Are you currently under the care of an M.D. for any condition. Yes __ No __

If Yes, please explain: _____

_____

Please rate the nutritional value of your total daily diet intake. Good __ Fair __ Poor __

If Fair or Poor, please explain : _____

Please check any of the following that apply.

- ☐ Significant weight gain/loss in the last six months
- ☐ Dieting
- ☐ Food/drug allergies
- ☐ Overeating or eating too little
- ☐ Problems chewing or swallowing

If any box is checked please explain:_____

_____

Do you have any functional limitations that affect your daily living (e.g. physical impairments, problems with self care, speech, vision, or hearing)? Yes ___ No ___

If Yes please explain: _____

Client Name:_____
Chart No. _____
Date: _____

9. Please list all *current* medications including over the counter and prescription medications.

Name of Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Please List *prior* medication for mental health issues, chemical dependency or alcohol use.

Name of Medication	Dosage	Date Started	Date Discontinued
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Legal History

Please place an **N** for none, **C** for currently experiencing or **P** for experienced in the past.

DUI	_____	Bankruptcy	_____	Divorce	_____
Unemployment	_____	Domestic Violence	_____	Custody Dispute	_____
Disability Claim	_____	Workman's compensation	_____		

12. Financial Problems:

_____

13. Educational Background:

_____

14. Employment History (Please describe current job briefly):

_____

15. Military Service:

_____

Client name: _____
Chart number: _____
Date: _____

16. History of Abuse

Please place an **N** for none, **C** for currently experiencing or a **P** for experienced in the past.

Verbal Abuse _____ Emotional Abuse _____ Childhood Abuse _____
Physical Abuse _____ Spouse Abuse _____
Sexual Abuse _____ Elder Abuse _____

17. Alcohol and Drug Use

Do you drink alcohol? Yes ___No___ If Yes, how often: _____
When was the last time you had a drink? _____
How much did you drink at that time? _____
Do you have any history of using non-prescribed drugs or abusing prescribed medications? Yes __ No __
Do you currently use any non-prescribed drug or abuse a prescribed medication? Yes __ No __

What substances have you used in the last 6 months? (Check all that apply.)

☐ Marijuana / "Pot" ☐ Cocaine ☐ Inhalants / "Huffing"
☐ LSD / "Acid" ☐ Amphetamines / "Speed" ☐ Other
☐ Pain Killers ☐ Sedatives / "Downers" ☐ None of Above

If 'Other' is checked, explain below.

_____
_____
_____

Check any of the following that has occurred as a result of your drinking or drug use.

☐ Arrest ☐ DUI ☐ Family Problems
☐ Public Intoxication ☐ Financial Problems ☐ Arguments
☐ Work Problems ☐ Health Problems ☐ Relationship Problems

18. Sexual/Affectional History

Are you satisfied with your sex life? _____ yes _____ no

Do you have any concerns or questions about your sexual orientation or experiences? (If so, please explain.)

_____

_____

19. Religious/Spiritual History

Do you feel you have any concerns or problems with your religion and/or spiritual beliefs? Please describe.

_____
_____

20. History of Harm to Self or Others

Do you currently have any urges/thoughts of hurting yourself? Yes___ No___
Any current urges/thoughts of hurting another? Yes___ No___
Any history of hurting self or suicide attempt? Yes___ No___
Any history of physical aggression toward another? Yes___ No___
If Yes on any question, please describe. _____

Assessment - Adult Report

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SYMPTOM CHECK LIST:

0) None:
1) Mild: Some Times/Some Concern/Brief Episode
2) Moderate: Often/Significant Worry/Lasts for a While
3) Severe: Very Often/High Intensity/Continuous

MOOD	
Loss of energy / fatigue	
Appetite Change (more or less)	
Social Withdrawal	
Crying	
Sleep Problems (more) (less)	
Feeling Hopeless	
Negative Thinking	
Depressed / Sad	
Self-Esteem Issues	
Concentration Trouble	
Blaming Self	
Blaming Others	
Dislike Being Touched	
Mood Swings	
Decreased Sex Drive	
Decreased Desire for Fun	
Social Embarrassment	
Panic Attacks	
Repeated Actions	
Repeated Thoughts	
Anxiousness /Anxiety	
Fears / Phobias	
Work/School Issues	
Absenteeism/Tardy	
Difficulty Holding a Job	

Poor Attitude	
Termination/Expelled	
Stress on Job/School	
BEHAVIOR	
Irritable	
Verbally Argumentative	
Physically Aggressive	
Throws Things	
Slams Doors	
Hits/hurts self	
Inattentive	
Impulsive	
Hyperactive	
Defiant / Stubborn	
Lies	
Stealing	
Overspending Issues	
Damages property	
RELATIONSHIPS	
Issues with Spouse/ Significant Other	
Issues with Children	
Issues with Parents	
Issues with Employer/Boss	
Issues with Co-workers	
Issues with Peers/Friends	
Grief/Loss Issues	

Trust Issues	
Issues with Teacher (School)	
SUBSTANCE ABUSE	
Alcohol Use	
Prescription Drug Use	
Non-Prescription Drug Use	
Loss of Control Over Use	
Cravings for Drugs/Alcohol	
Potential for Withdrawal from D/A	
Personality Changes When Using	
Blackouts from Drug/Alcohol Use	
THOUGHT PROCESSES	
Bizarre/Confused Thinking	
Believe Unusual Thoughts	
Hallucinations	
Disorganized Speech	
Suspicious	
Unaware of Time	
Unaware of Self	
Unaware of Surroundings	
Disorganized Behavior	
Thoughts of Hurting Self	
Thoughts of Hurting Others	

Other: _____