Child/Adolescent EAP Initial Assessment

Client Name: **Client ID #:**

Presenting Problem:

Symptoms (check those that apply):

Changes in sleep	Irritability/Moody	Angry outbursts
Appetite changes	Sadness	Increased tantrums
Weight changes	Anger	Deliberately disobeying rules
Fatigue/Tired	Anxious/Worries	Fighting with peers
Hyperactivity	Depressed mood	Disrespectful to authority figures
Body aches	Feeling overwhelmed	Increased use of sugar/caffeine
Headaches	Low energy	Alcohol use
Stomach aches	Difficulty concentrating	Drug use
Jumpiness	Forgetful	Other: ______________________

Notes:

Mental Health & Medication History: **(if 12 and up) PHQ-9 _____**

Medical Conditions (check those that apply):

None reported	Gastrointestinal	Allergies
Cardiovascular/Heart Disease	Migraines	Birth defects
Diabetes	Vision	Surgeries
Cancer	Hearing	Neurological
Muscular Skeletal	Asthma/Respiratory	Other:______________________

Notes:

School Functioning (check those that apply):

No problems at school	Overwhelmed with school work	Isolated/no friends
Absenteeism	Suspensions/Expulsions	Being bullied
Falling or failing grades	Problems with teachers/staff	Bullies others
Test anxiety	Fights with peers	Other:___________________________

Notes:

Relevant Family and Social History/Current Functioning:

Substance Use (check those that apply): AUDIT ____ DUDIT ____ (if reported/ suspected)

N/A Alcohol Marijuana (method of administration_________________) Nicotine	Cold medications Inhalants Hallucinogens (LSD/PCP) Cocaine	Amphetamines Benzodiazepines Opioids/Opiates Synthetics (spice, bath salts) Other:_____________________

Age of 1st Use: ________ Frequency of Use: ____

Previous Treatment: ____

Family Hx: ____

Notes:

Trauma History (check those that apply):

None reported Robbery/Break-ins Natural disaster	Domestic violence Physical abuse Sexual abuse Emotional abuse	Bullying Death/loss of family/friends Other_________________________

Notes:

Risk of Harm (check those that apply):

Suicidal: __ None __ Ideation __ Intent __ Plan __ Means __ Prior attempts **Harm to another**: __ None __ Ideation __ Intent __ Plan __ Means __ Prior attempts **Self-Harm:** __ None __ Yes - Method: ____

Assessment notes/Safety plan:

Plan/Goals to Increase Functioning:

____

Therapist Signature **Assessment Date**

EAP Progress Note

Client Name(s): **Date:**

Client ID #: **Current risk of harm?**

Client's progress on goals, significant changes, strategies to increase functioning:

____ ____________________

Therapist Signature **Date**