EAP Initial Assessment

Client Name(s): **Client ID #:**

Presenting Problem:

Symptoms (check those that apply):

Changes in sleep	Dizzy spells	Feeling overwhelmed
Appetite changes	Jumpiness	Low energy
Fatigue	Irritability/Moody	Inability to concentrate
Hyperactivity	Sadness	Forgetful/Memory lapses
Body aches	Anger	Increased use of sugar/caffeine
Headaches	Anxious	Increased alcohol use
Heart palpitations/chest pains	Depressed mood	Increased drug use

Other/notes:

Mental Health & Medication History: **PHQ-9 _____**

Medical Conditions (check those that apply):

None reported	Back problems	Asthma/Respiratory
Cardiovascular/Heart Disease	Gastrointestinal	High blood pressure
Diabetes	Migraines	Surgeries
Cancer	Vision	Neurological
Muscular Skeletal	Hearing	Other:
Fibromyalgia		

Notes:

Substance Abuse/Addictions (check those that apply): **AUDIT _____** **DUDIT _____**

N/A	Illicit drugs _______________	Sex	Shopping
Alcohol	Prescription drugs	Internet	Recovery (length): ________________
Marijuana	Nicotine	Gambling	Other ____________________________

Treatment HX/notes:

Client Name(s): **Client ID #:**

Relevant Family and Social History/Current Functioning:

Work Functioning (check those that apply):

No problems at work Missing deadlines Increased incidence of errors Increased absenteeism Tendency to underwork	Tendency to overwork Problems with superiors Problems with co-workers Communication issues Feeling productive	Work quality/quantity has decreased Satisfied with job Dissatisfied with job Other:

Notes:

Trauma History (check those that apply):

None reported Robbery Natural disaster	Domestic violence Physical abuse Sexual abuse	Emotional abuse 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

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**