Franciscan HEALTH
EMPLOYEE ASSISTANCE PROGRAM

CLIENT ASSESSMENT FORM

Today's Date: _____ Date of Birth: _____

Name: _____

Relation to EAP eligible employee: ☐Self ☐Spouse ☐Dependent ☐Parent ☐Other

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____

Where do you work: _____ Position: _____

Where does the eligible EAP employee work: _____

PRESENTING PROBLEM

Check all that apply:

☐Alcohol Use	☐Anger	☐Anxiety/Worrying	☐Child/Adult Trauma
☐Depression	☐Difficulty Sleeping	☐Drug use	☐Eating habits
☐Financial problems	☐Gambling	☐Harassment/Threats	☐Housing or food insecurity
☐Lack of Support	☐Legal Problems	☐Family conflict	☐Pain
☐Physical Health	☐Self-esteem	☐Time Management	☐Violence/Abuse
☐Grief	☐Workplace concerns	☐Parenting	☐Relationship/Marital Problems

☐Other: _____

What are the goals you wish to accomplish in counseling? _____

_____

Have you missed work because of your concern? ☐Yes ☐No How many days? _____

Have you ever been in counseling before? ☐Yes ☐No

If so, where, and when? _____

How satisfied are you with your life currently? ☐5 ☐4 ☐3 ☐2 ☐1 (5 is very, 1 is not at all)

How satisfied are you with your work currently? ☐5 ☐4 ☐3 ☐2 ☐1 (5 is very, 1 is not at all)

Are you currently seeing a Primary Care Physician/NP/PA? ☐Yes ☐No Who? _____

Are you currently seeing a psychiatrist/psych NP? ☐Yes ☐No Who? _____

Do you have health insurance? ☐Yes ☐No

If yes, what type of health insurance do you have? _____

Are you currently taking any psychiatric medications? ☐Yes ☐No

If so, what? _____

Are you currently taking any medications for medical reasons? ☐Yes ☐No

If so, what? _____

Names, ages, and relationship of those who live with you:

_____ _____

_____ _____

_____ _____

_____ _____

Do you feel safe at home? ☐Yes ☐No Do you feel safe in your current relationship? ☐Yes ☐No

Have you or an immediate family member served in the military? ☐Yes ☐No

If yes, which branch and dates of service: _____

Please list name and telephone # of emergency contact person: _____