Date:      Choose one:

**EAP Client Information**

Name:      DOB:       Gender:

**Employment History**

Employer:

Current job title and responsibilities:

Length of time employed at this position:

Degree of satisfaction with current employment:

Is there any history of work-related difficulties? If so, describe:

**Presenting Problem**

Describe:

**Social History**

Relationship Status: Single Married Separated Divorced Widowed

If applicable, describe the relationship:

Number of children: Biological       Step       Other

Ages of Children:

Is the presenting problem related to children Yes  No

If yes, please explain:

Describe relationship with children:

Current support systems:

Any other significant family history:

**Health History**

Significant health problems? Yes  No  If yes, describe:

Disabilities? Yes  No  If yes, describe:

Has this EAP client seen their medical practitioner within the past year?

Current Medications (if relevant):

Is EAP client currently active in a fitness program?

Does EAP client report sleep difficulties?

Does EAP client report healthy nutritional habits?

Does EAP client report difficulties coping with stress?

**Behavioral Health History**

Are any of the following signs or symptoms present at this time?

**Psychiatric or Emotional Problem:** Yes  No  Unsure  Past  Present

If yes or unsure, please explain:

**Depression:**  Yes  No  Unsure  Past  Present

*If unsure or suspicion of depression, please complete the brief depression screening tool located at the end of this assessment*

**Anxiety:** Yes  No  Unsure  Past  Present

*If unsure or suspicion of anxiety, please complete the brief anxiety screening tool located at the end of this assessment*

**Domestic violence:** Yes  No  Unsure  Past  Present

If yes or unsure, please explain:

**Anger Problems:** Yes  No  Unsure  Past  Present

*If unsure, or suspicion of anger problems, please complete the anger screening tool located at the end of this assessment.*

**Substance related disorder:** Yes  No  Unsure  Past  Present

*If unsure or suspicion of use, please complete the AUDIT for alcohol identification or DAST for drug identification attached at the end of this assessment*

**Imminent harm to self or others:** Yes  No  Unsure  Past  Present

If unsure, please explain:

**Any other behavioral concerns? Please explain:**

**Workplace Impact**

Was any workplace impact identified? Yes  No

If yes, please explain:

**Clinical Severity of Problem (choose one)**

1 Mild: Issues to be resolved within contracted number or fewer EAP sessions.

2 Short-term: Issues may be resolved within contracted number of EAP sessions,

referral may be made at the time EAP criteria is no longer met or at the

completion of EAP services.

3 No workplace impact is determined, referral will be suggested.

4 Client meets DSM IV DX criteria, referral will be suggested.

5 Unable to complete assessment, further assessment appointments will be scheduled.

Reason for additional assessments:

**Goals/Plan**

1:

2:

3:

4:

5:

6:

Please add any other relevant information here:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Signature/Degree of EAP Provider** **Agency (if applicable) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name Phone number**

**The Alcohol Use Disorders Identification Test (AUDIT)**

***Read questions as written. Record answers carefully. Place the correct answer number in the drop down box***.

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?   
   **--*Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0--***
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

Non-related scoring questions

1. When is the last time you had a drink containing alcohol (Date and Time)?
2. Have you ever been arrested due to an incident involving alcohol (i.e. DUI, DWI, disorderly conduct)?      . If Yes, how many?

**Scoring and Interpretation**

Audit Score Intervention

0 – 6 No referral

7+ Referral for assessment

**The Drug Abuse Screening Test (DAST):**

***Read each statement carefully. Check the appropriate box. Please be sure there are no missed questions.***

**YES** **NO**

1. Have you used drugs other than those required for medical reasons?

2. Have you taken more prescription drugs than were prescribed?

3. Have you had “blackouts” or “flashbacks” as a result of drug use?

4. Do you ever feel bad about your drug abuse?

5. Does your spouse (or parents) ever complain about your involvement    
 with drugs?

6. Do your friends or relatives or co-workers know or suspect you abuse

drugs?

7. Has drug abuse ever created problems between you and your spouse?

8. Have you ever lost friends because of your use of drugs?

9. Have you ever neglected your family or missed work because of your    
 use of drugs?

10. Have you ever lost a job because of drug abuse?

11. Have you gotten into fights when under the influence of drugs?

12. Have you ever been arrested because of unusual behavior while under    
 the influence of drugs?

13. Have you ever been arrested for driving while under the influence of drugs?

14. Have you engaged in illegal activities in order to obtain a drug?

15. Have you ever experienced withdrawal symptoms as a result of heavy    
 drug intake?

16. Have you been treated as an outpatient for problems related to drug abuse?

***Scoring and Interpretation***: A score of “1” is given for each YES response, except for items 4, 5, and 7, for which a NO response is given a score of “1.” Cutoff scores of 4 through 9 are considered to be optimal for screening for substance use disorders. Over 10 is definitely a substance abuse problem.

**Brief Depression Assessment**

Over the last two weeks, how often have you been bothered by the following problems:

1. Little interest or pleasure in doing things  Yes  No

2. Feeling down, hopeless  Yes  No

3. Trouble falling asleep, or sleeping too much  Yes  No

4. Feeling tired, lack of energy  Yes  No

5. Poor appetite  Yes  No

6. Feeling bad about yourself  Yes  No

7. Can’t concentrate (e.g. watching TV)  Yes  No

8. Thoughts of hurting yourself  Yes  No

EAP provider will make determination if the person is presenting possible depression.

**Brief Anxiety Screening Tool**

1. Feeling Nervous, anxious, or on edge:

2. Unable to stop worrying:

3. Worrying too much about different things:

4. Problems relaxing:

5. Feeling restless or unable to sit still:

6. Feeling irritable or easily annoyed:

7. Being afraid that something awful might happen:

**SCORING:**

Sum scores from each question:

* + None = 0
  + Several = 1
  + 7 or More = 2
  + Nearly every day = 3

*A total score of 5 – 9 suggests MILD anxiety*

*A total score of 10 or greater suggests MODERATE to SEVERE anxiety*

**Brief Anger Assessment**

**Score: 0 1 2 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Common Symptoms** | **Never** | **Sometimes** | **Frequently** | **Always** |
| When friends accuse you of being angry, you can prove them wrong. |  |  |  |  |
| I surprise myself by how angry I get and how I fight back. |  |  |  |  |
| People say they are afraid of me and avoid talking openly with me. |  |  |  |  |
| I have broken, thrown or kicked objects during an argument. |  |  |  |  |
| I feel hostility toward authorities and people who interfere with my actions. |  |  |  |  |
| I argue in a way that is verbally intimidating, loud and/or abusive. |  |  |  |  |
| I have bruised, shaken, slapped or hit someone during an argument. |  |  |  |  |
| I use body language to threaten e.g. clenched fist or jaw, glaring looks or refusal to make eye contact. |  |  |  |  |
| I have refused to participate socially due to anger and resentment. |  |  |  |  |
| I often make quick judgments and harsh statements about others. |  |  |  |  |

**Your Score Is: If your score is 1-10**Your score indicates mild to moderate difficulty with anger management that affects interpersonal relationships and interferes with conflict resolution. At this level, application of self-help information and practice with healthy assertiveness may resolve difficulties. Seek the feedback of those who know you well about the impact of your anger on them. Review your answers with someone close to you to identify repeating patterns in your angry reactions and seek help to gain better behavioral control over outbursts.

**If your score is 11-20**Your score indicates a moderate difficulty with anger, complicated by feelings of hostility and intermittent verbal or physical loss of control. You tend to deny the impact of your anger on others and there are times when your anger catches you off guard and leaves you defensive when confronted. Efforts to contain anger have unpredictable results and friends avoid discussions with you. Anger itself is a natural emotion; hostility and defensiveness are symptoms of underlying difficulty with self esteem or unrealistic expectations. Therapy at this level will help you to interrupt your automatic responses to disappointment or judgment, and help you to gain control over how you express yourself when upset.

**If your score is 21-30**Your score indicates a severe and growing problem with anger may change your relationships with others to the point of separation and chronic avoidance. You may find yourself preoccupied with thoughts of retaliation and a determination to undermine the actions of others who disagree with you. Friendships dwindle, relationship conflicts escalate without resolution and you are very tired of feeling blamed for everything – often without cause. At this level of severity, anger has truly made your life unmanageable and robbed you of your ability to respond calmly when you need to. You may even have encountered legal restraints or other charges related to anger. Therapy at this level will first help you contain your anger safely before it escalates out of control, change the habits of thinking that trigger outrage, and express yourself clearly without harm to self or others.