

ASSESSMENT FORM

(This form is optional and provided for your convenience. If you have your own form, you may use it. Please note that EAP best practices suggest that all assessments include a focus on any job or occupational impacts and on assessing for substance abuse.)

Client Name: _____ Assessment Date: _____

Employer: _____ DOB: _____ Sex: _____ Marital Status: _____

Clinician's Name: _____

1. Presenting and secondary Problems(s) (type, extent, onset, severity, precipitants): _____

2. Current and past marital, family, and relationship history: _____

3. Current Living Arrangement: _____

4. Medical and Psychiatric History (include present and past medical/psych problems and medications taken): _____

5. Alcohol and Drug Use (explore present and past use). Complete the EAPC Alcohol and Drug Assessment Form if there are indicators of a problem:

6. Family History of Alcohol and Drug Use: _____

7. Present and past job functioning (performance, satisfaction, stability, stress, quality of work relationships):

8. How presenting issue currently impacts work: _____

9. Type and degree of support from family, friends, and work: _____

10. Hobbies and Interests: _____

11. Financial Status (describe any problems/stressors): _____

12. Legal History (arrests, convictions, DUIs): _____

13. Substance Abuse and Psychiatric Treatment History (reason for, type, duration, dates, outcome): _____

14. Affect and Mental Status: _____

15. Suicidal Ideation or Attempts: (If yes, please describe past and present & family history of the same) _____

16. Violent/Homicidal Ideation or Attempts (If yes, please describe past and present) _____

17. History of being abused or neglected (If yes, please describe and do safety evaluation and plan)

18. History of being abusive or neglectful (If yes, please describe) _____

ASSESSMENT CONCLUSIONS:

DIAGNOSIS:

ICD 10# **Description**

ICD 10#	Description

Prognosis: _____

Signature of Clinician

Date

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