INITIAL CLIENT QUESTIONNAIRE

TODAY'S DATE: ______________________________

NAME: ____
LAST FIRST MI

NAME YOU WANT TO BE CALLED: ____

STREET ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP: ____________

CONTACT INFORMATION (Phone numbers you can be contacted at in priority order):

1ST PHONE NUMBER: ____________________________ ______CELL ______HOME _____WORK

2ND PHONE NUMBER: ____________________________ ______CELL ______HOME _____WORK

3RD PHONE NUMBER: ____________________________ ______CELL ______HOME _____WORK

SOCIAL SECURITY #: ______________________________ RACE: ______________

DATE OF BIRTH: ____________________ AGE: ______________ SEX: ______________

RELATIONSHIP STATUS: _______DIVORCED _______MARRIED _______WIDOW _______SINGLE
_______SEPARATED _______LIFE PARTNER _______COHABIT

LEVEL OF EDUCATION: __________ ARE YOU REQUIRED TO COME IN? _____YES _____NO

HOW DID YOU FIND OUT ABOUT US? ____________________________________

WHO REFERRED YOU (IF ANYONE)? _____________________________________

EMPLOYER: ______________________________ JOB TITLE: __________________

DATE OF HIRE: ___________________________ YEARS AT COMPANY: ___________

INSURANCE COVERAGE (Name of company): _____________________________

WHAT IS THE PRIMARY ISSUE/CONCERN THAT BROUGHT YOU IN TODAY? ___________

____

(**EAP CLIENTS ONLY**) ARE **YOU** THE: _______EMPLOYEE _______SPOUSE _______DEPENDENT

(Please Continue To Next Page)

PEOPLE WHO LIVE IN YOUR HOME:

FULL NAME	RELATIONSHIP	AGE

IMMEDIATE FAMILY MEMBERS NOT LIVING IN YOUR HOME:

FULL NAME	RELATIONSHIP	AGE

MEDICAL CHECKLIST

Please review and check any of the problems you are experiencing or have experienced in the past.
If you have a medical problem or problems that are not listed below please use the blank space provided to describe them.

______ ADD/ADHD
______ Alcoholism
______ Arthritis
______ Asthma & Allergy
______ Autism
______ Back Problems
______ Birth Defects
______ Blindness
______ Cancer
______ Cardio-Vascular
______ Cerebral Palsy
______ Cystic Fibrosis

______ Deafness
______ Developmental Disability
______ Diabetes
______ Drug Abuse
______ Eating Disturbance
______ Epilepsy
______ Headaches
______ Hearing Impairment
______ Heart Disease
______ Kidney Disease
______ Mental Illness

______ Mental Retardation
______ Multiple Sclerosis
______ Muscular Dystrophy
______ Respiratory Illness
______ Speech Problems
______ Sleeping Disorder
______ Stomach Problems
______ Tuberculosis
______ Venereal Disease
______ Weight Problems
______ Other

____

____

____

(Please Continue To Next Page)

MEDICATIONS

Please list medications you are currently taking.

____

____

____

____

Date of your last physical examination:________________________________

Using the scale below, please check which best describes problems you may have in the following areas:

	significant problem	some concern	no problem	doesn't apply
1. Raising children				
2. Relating to your significant other				
3. Dealing with your alcohol use				
4. Dealing with other drugs				
5. Dealing with your gambling				
6. Handling job related stress				
7. Managing finances				
8. Handling legal problems				
9. Handling psychological or emotional problems				
10. Alcohol or drug use in family				
11. Gambling in family				
12. Handling health problems				
13. Handling occupational problems				
14. Physical or sexual abuse				
15. Handling educational problems				
16. Other Problems (please describe):				

	YES	NO
17. Do you feel your job performance has been affected by the issue/concern that has brought you to EAP?		
18. Do you feel your job is in jeopardy at this time? If yes, explain:		
During the past year have you:		
19. Used an employee assistance program?		
20. Participated in treatment?		
21. Participated in self help groups?		