

PEOPLE WHO LIVE IN YOUR HOME:

FULL NAME	RELATIONSHIP	AGE

IMMEDIATE FAMILY MEMBERS NOT LIVING IN YOUR HOME:

FULL NAME	RELATIONSHIP	AGE

MEDICAL CHECKLIST

Regarding you and your immediate family members, please review and put the initials of the appropriate person by any of the problems experienced currently or in the past. If you have a medical problem or problems that are not listed below, please use the blank lines below to describe them.

- | | | |
|-------------------------------------------|---------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Deafness | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Asthma & Allergy | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Respiratory Illness |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eating Disturbance | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cardio-Vascular | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cystic Fibrosis | | |

(Please Continue To Next Page)

MEDICATIONS

Please list medications you are currently taking.

Date of your last physical examination: _____

Using the scale below, please indicate which best describes problems you or household members may have in the following areas, using the person's initials:

	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?		