Client Intake Survey

(To be completed by client/guardian)

This form is being completed verbally via telephonic counseling: Y N

Today's Date: _____

_____ _____ _____
Last Name *First Name* *MI*

( ) H C W *( ) H C W* *Email:* _____
Can We Leave a Message: Y N *Can We Leave a Message: Y N* *Can we follow up by email: Y N*

_____ _____ _____
Address *City/State* *Zip Code*

DOB: _____ *Circle One*: Male Female Other

Name of company providing EAP benefit:_____

Your relationship to the employee covered by EAP: ☐ *Self* ☐ *Spouse* ☐ *Partner* ☐ *Child* ☐ *Other*_____

List others attending today's session and their relationship to you: (example: Tom/Spouse)

_____ _____

_____ _____

Choose the reason for your visit today using a 1 as the primary reason for counseling, and 2 as the secondary reason.

Mental/Physical Health
___ *Medical/Physical*
___ *Grief/Major Loss*
___ *Depression*
___ *Anxiety*
___ *Suicidal*
___ *Other*

Addiction
___ *Alcohol*
___ *Drugs*
___ *Eating Disorder*
___ *Spending*
___ *Gambling*
___ *Other*

Relationships
___ *Marital/Partner*
___ *Family/Children*
___ *Abuse/Neglect*
___ *Co-worker/Supervisor*
___ *Identity/GLBTQ*
___ *Elder Care*
___ *Parenting*
___ *Other*

Work / Life
___ *Career Choices*
___ *Stress Reaction*
___ *Financial Management*
___ *Legal Concern*
___ *Work/Life Balance*
___ *Anger Management*

1. How did you find out about our services?

☐ Been Here Before
☐ Company Newsletter
☐ Literature or Poster
☐ Seminar / Orientation
☐ Co-Worker
☐ Manager or Supervisor
☐ Human Resources
☐ Partner/Spouse/Relative
☐ Insurance Plan / Health Coach
☐ Clergy / Spiritual Leader
☐ Healthcare Provider
☐ Website/Internet
☐ Return To Work Coaching Referral
☐ Employer Referral – Required
☐ Other_____

Client Name: _____

Work and Health related questions (Please answer all that apply for the person using this service)

The following questions relate to the impact of your concerns on your daily activities, your work, and your overall health. Your responses may provide additional insights to assisting with your concerns and be beneficial in measuring and assessing the success of our program.

2. How would you rate your current job satisfaction?

- ☐ *Excellent*
- ☐ *Good*
- ☐ *Average*
- ☐ *Poor*
- ☐ Very *Poor*

3. During the past 4 weeks, have you been preoccupied at work and could not concentrate or be productive due to the issue(s) you are contacting us about? ☐ *Yes* ☐ *No*

4. During the past 4 weeks, have you been absent from work because of the issue(s) you are contacting us about?

☐ *Yes* ☐ *No*

5. In general, how would you rate your overall health?

☐ *Excellent* ☐ *Good* ☐ *Average* ☐ *Poor* ☐ Very *Poor*

6. In the past 2 weeks have you experienced any of the following?

- ☐ *Depressed mood or excessive sadness*
- ☐ *Poor concentration*
- ☐ *Increased or decreased appetite/weight gain or weight loss*
- ☐ *Sleeping problems/increased sleeping or trouble sleeping*
- ☐ *Loss of interest in activities / lack of motivation*
- ☐ *Feeling worthless or guilty*
- ☐ *Suicidal thoughts/thoughts of death*
- ☐ *Fatigue*

7. If this service had not been available to you what would you have done?

- ☐ *Contacted family physician*
- ☐ *Contacted a crisis line or social services organization*
- ☐ *Contacted my supervisor/co-worker*
- ☐ *Nothing*
- ☐ *Contacted a therapist, psychiatrist, or psychologist*
- ☐ *Contacted a friend*
- ☐ *Contacted my clergy/faith leader*
- ☐ *Other*

8. How would you rate your overall health <u>compared to one year ago?</u>

- ☐ *Much better now than one year ago*
- ☐ *Somewhat better now than one year ago*
- ☐ *About the same as one year ago*
- ☐ *Somewhat worse now than one year ago*
- ☐ *Much worse now than one year ago*

9. Are you in any relationship that causes you concern for your safety or the safety of others?

☐ *Yes* ☐ *No*