EAP CLINICAL ASSESSMENT FORM

Client Name:_____ Date of Assessment:_____

Employee Name: _____ Date of Birth: _____

Presenting Problem: _____

_____

_____

Client's Expected Outcome: _____

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Current Signs/Symptoms

Acute Stress	( )yes ( ) no	**Pressured speech**	( )yes ( ) no	**Loose associations**	( ) yes ( ) no
Depressed mood	( )yes ( ) no	**Weight loss/gain**	( )yes ( ) no	**Psychomotor retardation**	( )yes ( ) no
Appetite disturbance	( )yes ( )no	**Panic attacks**	( )yes ( ) no	**Concentration/ attention problems**	( )yes ( ) no
Sleep disturbance	( )yes ( ) no	**Phobias**	( )yes ( ) no	**Impulse control problems**	( )yes ( )no
Low energy	( )yes ( )no	**Agitation**	( )yes ( )no	**Binging / purging**	( )yes ( ) no
Conduct problems	( )yes ( )no	**Sexual dysfunction**	( )yes ( )no	**Irritability**	( )yes ( ) no

Mental Status

Oriented x3	( )yes ( )no	**Impaired memory**	( )yes ( )no	**Delusions**	( )yes ( )no
Impaired judgment	( )yes ( )no	**Other cognitive impairment**	( )yes ( ) no	**Hallucinations**	( )yes ( )no

Risk Assessment (Explain any positive findings)

Suicidal Risk		**Homicidal Risk**		**Abuse Risk**	
Ideation	( )yes ( )no	**Ideation**	( )yes ( )no	**Verbal**	( )yes ( )no
Intent	( )yes ( )no	**Intent**	( )yes ( )no	**Emotional**	( )yes ( )no
Plan	( )yes ( )no	**Plan**	( )yes ( )no	**Physical**	( )yes ( )no
Means	( )yes ( )no	**Means**	( )yes ( )no	**Sexual**	( )yes ( )no

Actions taken regarding risk factors: _____

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Substance Use Assessment

Drug/Alcohol Use (For past 12 months) ( )yes ( )no if yes complete following.

Substance	**Amount**	**Frequency**	**Age Began**	**Last Used**

Strengths/Resources

( ) Family support
( ) Relationship stability
( ) Intellectual cognitive skills
( ) Coping skills resiliency
( ) Insight
( ) Parenting skills
( ) Socio-economic stability
( ) Communication skills
( ) Community support
( ) Spirituality/Religious affiliations
( ) Other:

Summary of Action Plan:

_____

_____

_____

_____

_____ _____

Clinician Signature/Credentials/Date **Client Signature/Date**