Health Promotion Northwest Employee Assistance Program (EAP)

Standard Questionnaire

N/ Word/ Forms/ Questionnaires for Intake / Questionnaire-Standard – For Adults or Teens 13+…. Rvsd 8/16

CONFIDENTIAL CLIENT QUESTIONNAIRE: Completion of this questionnaire provides background information that gives the EAP counselor a better understanding of the current issue/concern and the context of your life experience. If you have a concern or question about any item please feel free to leave it blank until you speak with the counselor.

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Today's Date: _____

First, Middle, Last Names _____ **Date of Birth:** ___/___/___ **Age**: ____

Social Security #: __XXX_/__XX__/_____ **Gender:** ☐ Male ☐ Female ☐ Other Preference
(We data enter the last 4 SSN digits into computer only)

The Employer that is providing the EAP Benefit:_____
If this is not your Employer, what is the name of the Employee who works for the above Employer?_____
What is the Employee's relationship to you?_____

Your Employer (Company) _____ Your Job Title _____

Worksite Location/Dept._____ Length of Employment_____

Referred by (self, supervisor, other) _____ Supervisor's Name: _____

Your Mailing Address_____ Your Cell Phone # _____

Your Home Phone # _____

(City/State/Zip)_____

Your Work Phone # _____

Email Address: _____ What is the best way to reach you? _____

If we need to contact you by phone, can we identify our place of business as HPN to whoever answers the phone?
At your primary #: ☐ Yes ☐ No At your home: ☐ Yes ☐ No At your work: ☐ Yes ☐ No

The following Insurance information is requested to aid us in providing you with referrals:

What is the name of your Medical Insurance Company? _____
If you are not the subscriber (policy holder) please provide the following information regarding the Subscriber:
Name _____ Their Relationship to you_____

Education/Family

Years of Education (K-12) _____ College/Vocational Course of Study? _____ Degree/ Cert's._____
Are you a veteran of the Armed Forces? ___Yes ___No Year Enlisted: _____ Year Discharged: _____

What persons are in your household? (alone, spouse/partner, friend, kids, etc)_____
Marital / Relationship status (single, married / partnered, separated, divorced, other) _____
Name of Spouse/Significant Other_____ Length of relationship_____ Length of separation_____

Children / Step Children:
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____

Quality Assurance Survey: To ensure that we are providing the highest quality of services, we conduct anonymous confidential surveys. These surveys allow you to evaluate the services you've received at Health Promotion Northwest. Statistical summaries may be shared with employers or other organizations, but please be assured that your confidentiality will not be compromised in any way. Do we have your permission to send a survey to your home through the U.S. Postal Service? ☐ *YES* ☐ *NO*

Health:
Your Primary Care Physician's Name: _____
How many times have you consulted your physician in the past year? _____ Regarding: _____
Estimate the number of hours of sick leave used in the past six months._____ Is this standard? _____
How would you describe your physical health today? ___Very Poor ___Poor ___Average ___Good ___Excellent
How would you describe your emotional health today? ___Very Poor ___Poor ___Average ___Good ___Excellent

___Yes ___No Have you experienced any medical problems that you would want us to know about?
___Yes ___No Are you (or have you been) concerned about your weight and/or eating habits.
___Yes ___No Have you ever fractured a bone?
___Yes ___No Have you consulted a mental health professional in the past year? Their Name? _____
___Yes ___No Are you currently seeing a counselor? Their Name? _____
___Yes ___No Using any Non-Prescription (over-the-counter or other) Medications? Type, Dosage: _____
___Yes ___No Are you currently (or in the past year) using any prescription medication?
Drug(s) Name/type, Dosages & Prescriber_____

Do you experience any of the following?

___ Difficulty Sleeping	___ Excessive Worry	___ Increased Crying	___ Muscle Spasms
___ Headaches	___ Tension under Stress	___ Increase in Weight	___ Memory Loss
___ Backaches	___ Fatigue	___ Decrease in Weight	___ Chest Pains
___ Nervousness	___ Increased Irritability	___ Restlessness	___ Dizziness

Alcohol and/or Other Drug Use:
___Yes ___No Do you drink beer, wine or hard liquor? If yes, how often do you use alcohol?
___Daily ___3-4 Days/Week ___Weekends ___1-2 Times/Month ___2-6 Times/Year
What is the longest period of time you've gone without alcohol?_____
What is the longest period of time you've gone without drugs?_____

___Yes ___No Is there a history of alcohol problems in your family?
___Yes ___No Do you have a relative who you consider a heavy drinker?
___Yes ___No Has anyone ever expressed concern about your use of alcohol or drugs?
___Yes ___No Do you use tobacco products?
___Yes ___No Have you experimented with drugs other than alcohol?
Types of Drugs that you have experimented with: _____
The Age at which you last experimented (or currently using?):_____
___Yes ___No Are drug or alcohol issues one of the primary issues you want to discuss today?

Life/Work/Relationships:
___Yes ___No I exercise regularly.
___Yes ___No Generally, I feel rested when I awaken in the morning.
___Yes ___No My daily life is full of things that keep me interested.
___Yes ___No I am often depressed or moody.
___Yes ___No I am concerned about my family relationships.
___Yes ___No I am concerned about my career development.
___Yes ___No I have more conflicts with co-workers or supervisors than I want.
___Yes ___No When I was a child, I felt neglected or betrayed by my parents.
___Yes ___No Were you ever inappropriately touched or hurt as a child?
___Yes ___No If you answered yes to the question above, is this an issue you want to discuss today?
___Yes ___No Sometimes, I have difficulty remembering events of the previous day.
___Yes ___No I feel more isolated or lonely now than in the past.
___Yes ___No Have you ever had your driver's license suspended or revoked?
___Yes ___No Have you been in a physical fight since you were 18 years old?
___Yes ___No Have you ever been arrested?
___Yes ___No I have at times become so frustrated or angry that I physically struck another person or object.
___Yes ___No I sometimes wake up during the night feeling restless.

How long does it take you to fall asleep? _____ How many hours of sleep per night feels good for you? _____
How many hours of sleep have you been getting per night lately? _____

What would you like to accomplish with your EAP Counselor? _____
_____
_____
_____