EAP INTAKE FORM

Instructions: Please **PRINT** and complete **ALL** information. Fill in the box next to chosen category. Please use ink.

Date of Initial Assessment: ____________________

EAP PARTICIPANT DEMOGRAPHIC INFORMATION

Name: ______________________ Age: _______ Date of Birth: ____________________ ☐ Male ☐ Female

Insurance Company: ____________________ Member ID: ____________ Social Security Number: __ __ __ - __ __ - __ __ __ __

Education: ☐ Less than High School ☐ High School or GED ☐ Some College ☐ College Graduate ☐ Post Grad

Race: ☐ African Am. ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Native Am. ☐ Multicultural ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

Current Employment Status: ☐ Unemployed ☐ Employed Full-time ☐ Employed Part-time

Employee Name: (if not participant) Last: ____________________ First: ____________________ MI: _______

SS #: ______________________ Phone#: (__________) ____________________

EAP Clinician Name: ____________________ Group / Facility: ____________________

☐ EAP Provider or ☐ PENN Behavioral Health EAP Staff Phone#: (__________) ____________________

EMPLOYMENT DATE *(Complete section only if Employee is Participant)*

Employment Status
☐ Full time
☐ Part Time
☐ Promoted
☐ Terminated
☐ Medical Leave
☐ Disciplinary Leave
☐ Laid Off
☐ Disability/WC Leave
☐ Other: ________________

Job Dysfunction
☐ None
☐ Minimal
☐ Moderate
☐ Significant – no job jeopardy
☐ Significant – job jeopardy

Wage Category
☐ Salaried (exempt)
☐ Salaried – (non-exempt)
☐ Hourly
☐ Other: ________________
☐ Undisclosed

Union Member?
☐ Yes
☐ No

Job Problem ☐ **N/A**
(fill in all that apply)
☐ Absenteeism
☐ Fitness for Duty
☐ Safety
☐ Lateness
☐ Positive Drug Screen
☐ Productivity
☐ Quality of Work
☐ Co-Worker Relationship
☐ Supervisor Relationship
☐ Disability/Medical Leave(s)
☐ Workplace Violence: Threat to others by client
☐ Workplace Violence: Threat against client by others
☐ Affected by environmental & violence at work

Job Title
☐ Administration/Management
☐ Physician
☐ Nurse (RN)
☐ Technical
☐ Faculty
☐ Other Professional
☐ Clerical
☐ Service/Maintenance
☐ N/A

Regular Work Hours
☐ Days ☐ Weekends
☐ Afternoons ☐ Swing
☐ Nights ☐ Other: ____________

Employee Hire Date: ____________________

Supervisor Name: (for formal and mandatory referrals only) ____________________

Supervisor Phone #: (__________) ____________________

Company Name: ____________________ **Department:** ____________________

PRESENTING AND ASSESSED PROBLEM(S)

From the total list below, choose one presenting problem (P), one primary assessed problem (A_1), and one secondary assessed problem (A_2)

I. Environmental

P	A_1	A_2	
☐	☐	☐	Job/occupational
☐	☐	☐	Career planning
☐	☐	☐	Legal
☐	☐	☐	Childcare
☐	☐	☐	Eldercare
☐	☐	☐	Marital/relationship
☐	☐	☐	Domestic violence
☐	☐	☐	Sexual issues
☐	☐	☐	Family
☐	☐	☐	Anothers substance abuse
☐	☐	☐	Anothers medical problem
☐	☐	☐	Financial
☐	☐	☐	Other: ____________

II. Behavioral

P	A_1	A_2	
☐	☐	☐	Anxiety
☐	☐	☐	Depression
☐	☐	☐	Other mood disorder
☐	☐	☐	Stress
☐	☐	☐	Grief/Loss
☐	☐	☐	Alcohol use, client
☐	☐	☐	Drug use, client
☐	☐	☐	Other addictions, client
☐	☐	☐	Eating problems/disorder
☐	☐	☐	Psychosis
☐	☐	☐	Learning problems
☐	☐	☐	Other: ____________

III. Medical

P	A_1	A_2
☐	☐	☐

Describe symptoms: ____________________
____
____
____

Describe mental status: ____________________
____
____
____
____
____
____
____

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PENN BEHAVIORAL HEALTH CORPORATE SERVICES

Client Name ______________________ Social Security Number __ __ __ - __ __ - __ __ __ __

HISTORY

Work History: ______________________

____

____

Psychosocial History: ______________________

____

____

Treatment History (List any mental health and/or substance abuse treatment) ☐ N/A

Name of Facility or Therapist	When Treated?	What Treated For?

MEDICATIONS

Pt. on Psychotropic Medication? ☐ Yes ☐ No If yes, fill in box next to all that apply and list medications below

☐ Antidepressant ☐ Anxiolytic ☐ Antipsychotic ☐ Mood Stabilizer ☐ Sedative/Hypnotic ☐ Stimulant ☐ Other ☐ Unknown

Specify: ______________________

Other Medication? ☐ Yes ☐ No If yes specify: ______________________

____

Drug Allergies/Adverse reactions: ☐ Yes ☐ No If yes, specify: ______________________

RISK ASSESSMENT

Suicidality:	☐ Denies	☐ Ideation with Plan	☐ Ideation w/o Plan	☐ Intent with Means	☐ Intent w/o Means
Homicidality:	☐ Denies	☐ Ideation with Plan	☐ Ideation w/o Plan	☐ Intent with Means	☐ Intent w/o Means
Violent Behavior/Agression:	☐ Denies	☐ Ideation with Plan	☐ Ideation w/o Plan	☐ Intent with Means	☐ Intent w/o Means

Describe Current Risk and History of Harm to Self or Others: ______________________

____

DIAGNOSTIC IMPRESSIONS *(if applicable)* (Please Enter DSM IV Codes) ■ N A

Axis I: Code: __________ Diagnosis: ______________________

Code: __________ Diagnosis: ______________________

Axis II: Code: __________ Diagnosis: ______________________

Axis III: Medical Condition(s): ______________________

Axis IV: (Stressors) ______________________ **Axis V:** Current GAF: __________

Case Summary: ______________________

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