St. Elizabeth Healthcare
Employee Assistance Program

Assessment - Couples Report

Date of Birth: __________ **Age:** ___________

Client Name:________________________________
Chart No. ________________________________
Date: ________________________________

1. Why have you come to EAP (Presenting issue for Client)?

____

____

____

2. How long has this been an issue?

____

3. What have you tried to do to resolve this issue?

____

____

4. What are your goals for counseling?

____

____

____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems and chemical dependency/use.)

____

____

____

____

6. Has any member of your family, including grandparents, been diagnosed or had significant problems with mental health issues, alcohol use or chemical dependency? If so, please explain

____

____

Client name: ______________________
Chart number: ______________________
Date: ______________________

7. Who resides with you in your home.

Name	Age	Relationship
________________________	________	___________________
________________________	________	___________________
________________________	________	___________________
________________________	________	___________________
________________________	________	___________________

8. Health (describe your general health as well as any chronic conditions including pain)

____

____

____

When was your last complete physical exam by an M.D.________________________

Are you currently under the care of an M.D. for any condition. Yes __ No __

If Yes, please explain: ____

____

Please rate the nutritional value of your total daily diet intake. Good __ Fair __ Poor __

If Fair or Poor, please explain : ____

Please check any of the following that apply.

- ☐ Significant weight gain/loss in the last six months
- ☐ Food/drug allergies
- ☐ Problems chewing or swallowing
- ☐ Dieting
- ☐ Overeating or eating too little

If any box is checked please explain:____

____

Do you have any functional limitations that affect your daily living (e.g. physical impairments, problems with self care, speech, vision, or hearing)? Yes ___ No ___

If Yes please explain: ____

Client Name: ________________________________
Chart No. ________________________________
Date: ________________________________

9. Please list all *current* medications including over the counter and prescription medications.

Name of Medication	Dosage	Date Started
____________________	__________	____________
____________________	__________	____________
____________________	__________	____________
____________________	__________	____________

10. Please List *prior* medication for mental health issues, chemical dependency or alcohol use.

Name of Medication	Dosage	Date Started	Date Discontinued
____________________	__________	________	________
____________________	__________	________	________
____________________	__________	________	________
____________________	__________	________	________

11. Legal History

Please place an **N** for none, **C** for currently experiencing or **P** for experienced in the past.

DUI	______	Bankruptcy	______	Divorce	______
Unemployment	______	Domestic Violence	______	Custody Dispute	______
Disability Claim	______	Workman's compensation	______		

12. Financial Problems

____

13. Educational Background

____

14. Employment History (Please describe current job briefly)

____

15. Military Service:

____

Client name: ____________________
Chart number: ____________________
Date: ____________________

16. History of Abuse

Please place an **N** for none, **C** for currently experiencing or a **P** for experienced in the past.

Verbal Abuse ______ Emotional Abuse ______ Childhood Abuse ______
Physical Abuse ______ Spouse Abuse ______
Sexual Abuse ______ Elder Abuse ______

17. Alcohol and Drug Use

Do you drink alcohol? Yes ___No___ If Yes, how often: ____________________
When was the last time you had a drink? ______________________________
How much did you drink at that time? ______________________________
Do you have any history of using non-prescribed drugs or abusing prescribed medications? Yes __ No __
Do you currently use any non-prescribed drug or abuse a prescribed medication? Yes __ No __

What substances have you used in the last 6 months? (Check all that apply.)

- ☐ Marijuana / "Pot"
- ☐ Cocaine
- ☐ Inhalants / "Huffing"
- ☐ LSD / "Acid"
- ☐ Amphetamines / "Speed"
- ☐ Other
- ☐ Pain Killers
- ☐ Sedatives / "Downers"
- ☐ None of Above

If 'Other' is checked, explain below.

____
____
____

Check any of the following that has occurred as a result of your drinking or drug use.

- ☐ Arrest
- ☐ DUI
- ☐ Family Problems
- ☐ Public Intoxication
- ☐ Financial Problems
- ☐ Arguments
- ☐ Work Problems
- ☐ Health Problems
- ☐ Relationship Problems

18. Sexual/Affectional History

Are you satisfied with your sex life? _____ yes _____ no
Do you have any concerns or questions about your sexual orientation or experiences? (If so, please explain.)

____
____

19. Religious/Spiritual History

Do you feel you have any concerns or problems with your religion and/or spiritual beliefs? Please describe.

____
____

20. History of Harm to Self or Others

Do you currently have any urges/thoughts of hurting yourself? Yes___ No___
Any current urges/thoughts of hurting another? Yes___ No___
Any history of hurting self or suicide attempt? Yes___ No___
Any history of physical aggression toward another? Yes___ No___
If Yes on any question, please describe. ______________________________
____

Assessment - Couples Report

SYMPTOM CHECK LIST:

0) None:
1) Mild: Some Times/Some Concern/Brief Episode
2) Moderate: Often/Significant Worry/Lasts for a While
3) Severe: Very Often/High Intensity/Continuous

Client Name: ______________________________
Chart No. ______________________________
Date: ______________________________

MOOD	
Loss of energy / fatigue	
Appetite Change (more or less)	
Social Withdrawal	
Crying	
Sleep Problems (more) (less)	
Feeling Hopeless	
Negative Thinking	
Depressed / Sad	
Self-Esteem Issues	
Concentration Trouble	
Blaming Self	
Blaming Others	
Dislike Being Touched	
Mood Swings	
Decreased Sex Drive	
Decreased Desire for Fun	
Social Embarrassment	
Panic Attacks	
Repeated Actions	
Repeated Thoughts	
Anxiousness /Anxiety	
Fears / Phobias	
Work/School Issues	
Absenteeism/Tardy	
Difficulty Holding a Job	
Poor Attitude	
Termination/Expelled	
Stress on Job/School	

BEHAVIOR	
Irritable	
Verbally Argumentative	
Physically Aggressive	
Throws Things	
Slams Doors	
Hits/hurts self	
Inattentive	
Impulsive	
Hyperactive	
Defiant / Stubborn	
Lies	
Stealing	
Overspending Issues	
Damages property	

RELATIONSHIPS	
Issues with Spouse/ Significant Other	
Issues with Children	
Issues with Parents	
Issues with Employer/Boss	
Issues with Co-workers	
Issues with Peers/Friends	
Grief/Loss Issues	
Trust Issues	
Issues with Teacher (School)	

SUBSTANCE ABUSE	
Alcohol Use	
Prescription Drug Use	
Non-Prescription Drug Use	
Loss of Control Over Drug/Alcohol Amounts Used	
Cravings for Drugs/Alcohol	
Potential for Withdrawal from Drugs/Alcohol	
Personality Changes When Using Drugs/Alcohol	
Blackouts from Drug/Alcohol Use	

THOUGHT PROCESSES	
Bizarre/Confused Thinking	
Believe Unusual Thoughts	
Hallucinations	
Disorganized Speech	
Suspicious	
Unaware of Time	
Unaware of Self	
Unaware of Surroundings	
Disorganized Behavior	
Thoughts of Hurting Self	
Thoughts of Hurting Others	

Other: ______________________________
____
____
____

Couples Questionnaire

Client Name:	____________________
Chart No.	____________________
Date:	____________________

0) Never
1) Sometimes
2) Often
3) Very Often

(Circle an Option)

Statement					
1. When I have a decision to make, I include my partner.	0	1	2	3	
2. I believe my partner could do much more for me if they wanted to.	0	1	2	3	
3. I need to have one person who puts me above all others.	0	1	2	3	
4. I fear I will lose the love and support of my partner.	0	1	2	3	
5. The best way to get my partner to do something for me is to ask.		0	1	2	3
6. I use pressure to get what I want.	0	1	2	3	
7. I prefer avoiding arguments.	0	1	2	3	
8. I get unpleasant feelings when I realize I am about to get into an argument.	0	1	2	3	
9. I need to be committed to someone to have sex with that person.	0	1	2	3	
10. It is possible to enjoy sex with a person and not like that person very much.	0	1	2	3	
11. Being friends with my partner is important.	0	1	2	3	
12. My partner meets my needs.	0	1	2	3	
13. My marital relationship is my most important relationship.	0	1	2	3	
14. Having a satisfying relationship is more important to me than my partner.	0	1	2	3	
15. My partner and I work together to find solutions to our problems.	0	1	2	3	
16. My partner and I enjoy spending time with one another.	0	1	2	3	
17. My partner values my opinion.	0	1	2	3	
18. I value my partner's opinion.	0	1	2	3	
19. I am satisfied with my relationship with my partner.	0	1	2	3	

Name of Person Filling Out Form: ______________________________