
Has client been intoxicated, hungover, or in withdrawal at times when he/she is expected to fulfill important obligations, such as while at work?

Yes No

If Yes, describe: _____

Has client given up occupational, social or recreational activities because of substance use? Yes No

If Yes, describe: _____

Has client used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever?

Yes No

If Yes, describe: _____

Work problems:

- Violation of the Employer's substance abuse policy, example: a positive drug test.
- Absenteeism Tardiness Accidents
- Working while hung-over Trouble concentrating
- Decreased job performance Consumed substances while at work
- Lost job in past due to substance abuse No work problems

Comments: _____

Client's perception of substance use:

- Not a problem Unsure if problem Some problem
- Significant problem Severe problem Actively wants help

Family problems that are pre-existing, or are exacerbated by substance use:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Quarrels | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Family abuses alcohol/ drugs |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Child Neglect | <input type="checkbox"/> Family worried about client's use |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorce | <input type="checkbox"/> None |

Legal problems:

- DUI Public intoxication Other substance-related arrest None

Other (specify) _____

Financial problems: Some Moderate Severe None

Describe: _____

Social problems: Some Moderate Severe None

Describe: _____

Mental health disorders that are pre-existing, or have been exacerbated by substance use: _____

- Physical or medical problems:**
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Increased tolerance | <input type="checkbox"/> Hangovers | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach ailments |
| <input type="checkbox"/> Experiences withdrawal symptoms | <input type="checkbox"/> Heart ailments | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Other medical problems |

Comment: _____

Medications currently being prescribed (specify): _____

Evidence of psychological dependence to substances? Yes No

Comment: _____

Has the client attempted to cut down or stop alcohol and drug use: Yes No

(Describe) _____

- Control over use:**
- | | | |
|--|---|---|
| <input type="checkbox"/> No loss of control | <input type="checkbox"/> Uses more than intends | <input type="checkbox"/> Getting worse |
| <input type="checkbox"/> Unpredictable | <input type="checkbox"/> Uses to get high | <input type="checkbox"/> Gets argumentative |
| <input type="checkbox"/> Increased tolerance | | |

History of suicide attempts (describe): _____

History of violent behavior (describe): _____

Previous treatment: None Yes
(Describe: date, type, setting, and outcome) _____

Reports from collateral contacts (spouses, family, friends) concerning the client's substance use: _____

Additional Assessment Comments: _____

Multi-Axial DSM IV Diagnostic Impressions

- Axis I:** _____
Axis II: _____
Axis III: _____
Axis IV: _____

Axis V: _____

Prognosis: Excellent Good Fair Poor

Your recommendations for this client's treatment: (please check all that apply)

- Intensive outpatient substance abuse treatment program Duration _____
- Inpatient substance abuse treatment or detoxification Duration _____
- Self-help or 12 Step Groups Frequency _____ Duration _____
- Random Drug Testing Frequency _____ Duration _____
- Other outpatient treatment Frequency _____ Duration _____

Additional comments about treatment recommendations, or if you conclude that no further EAP or treatment services are needed or recommended, please comment: _____

Please specify the program, facility or counselor you are recommending to provide above services:

Name: _____

Location: _____

Telephone # if known: _____

Date the client agrees to begin treatment: _____

Additional comments: _____

Counselor Signature

Date

Thank you.

PLEASE SUBMIT TO:
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