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CLINICAL ASSESSMENT AND TREATMENT PLAN

Please fax or e-mail assessment form to EAP Works after the first session.

Clinician Name:_____ Date:_____

Client Name:_____ Date of Birth:_____

CHIEF COMPLAINT

Please describe the client's primary concern; history of the complaint; precipitating events; and any impact on client's work.

_____

_____

_____

SYMPTOM INVENTORY

__Generalized anxiety	__Sadness	__Anger	__Suspiciousness
__Panic attacks	__Sleep disturbance	__Agitation	__Fatigue
__Dissociation	__Withdrawal	__Tangential thinking	__Delusions/Hallucinations
__Distractibility	__Impulsiveness	__Impaired memory	__Obsessions/Compulsions

__Other:_____

RISK ASSESSMENT

Suicide: __None __Ideation __Intent __Plan __Means __Attempt

Explain: _____

Homicide: __None __Ideation __Intent __Plan __Means __Attempt

Explain: _____

Physical/sexual abuse: __Denies __Yes If yes, explain: _____

Client **__can** or **__cannot** agree to a contract not to harm __self __others __both

SUBSTANCE USE ASSESSMENT

	Current	Past
Wants or needs to cut down on drinking or drug use	_____	_____
Someone has objected to client's drinking/drug use	_____	_____
Uses alcohol/drugs to relieve emotional discomfort, sadness, anger, etc.	_____	_____
Neglected personal or work responsibilities because of alcohol/drugs	_____	_____

Substance	Current Use	Past Use	Substance	Current Use	Past Use	Substance	Current Use	Past Use
Alcohol			Amphetamines			Barbiturates		
Marijuana			Benzodiazepines			Opiates		
Cocaine			Inhalants			LSD		
Nicotine			Caffeine			Other:		

Notes:_____

_____

FAMILY HISTORY OF MENTAL HEALTH AND/OR SUBSTANCE ABUSE ISSUES

Describe:

_____

_____

PRIOR COUNSELING, PSYCHIATRIC, AND/OR SUBSTANCE ABUSE

Describe (Inpatient/outpatient; dates; providers; results):

_____

_____

MEDICAL STATUS

Describe (Relevant current/past conditions; most recent primary care visit; current medications):

_____

_____

PSYCHOSOCIAL STRESSORS

__Work / career __Financial __Housing __Legal ___Health __Family __Other

Explain:_____

DSM 5 DIAGNOSIS (OPTIONAL)

Diagnosis:_____ Code:_____ Prognosis:_____

Diagnosis:_____ Code:_____ Prognosis:_____

Significant psychosocial and contextual features:_____

TREATMENT PLAN

Describe interventions and objectives:

1. _____

2. _____

3. _____

EAP Counselor Signature:_____ Date:_____

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CLIENT TRACKING, CASE CLOSING, AND BILLING SUMMARY

Please fax or e-mail this form to EAP Works upon completion of all sessions for prompt payment.
Ph: 1-844-361-4348, Fax: 770-449-8113 or email: info@eapworklife.com

CLIENT INFORMATION

Name:_____ Date of birth:_____

Chief complaint:_____

SESSION INFORMATION

Number approved:_____ Modality: ☐ Face to face ☐ Telephone ☐ Video

DATE	PRESENTING ISSUE	NUMBER OF PEOPLE SERVED

CASE CLOSING INFORMATION

REQUIRED: Is this case closed? ☐ Yes ☐ No

Name of patients insurance provider:_____

Referrals (Must be in client's network; check all that apply, include self-referrals)

☐ OtPt Mental Health
☐ InPt Mental Health
☐ OtPt Chem. Dep.
☐ InPt Chem. Dep.
☐ Other (list):_____

☐ Anger Mgmt.
☐ Legal
☐ Financial
☐ Medical

☐ Support Group:
☐ AA ☐ CA ☐ EA
☐ OA ☐ Al-Anon
☐ NA

Estimated referral treatment length of time & frequency of visits:_____

Name of professional providing services beyond the EAP:_____

Closed case summary (include medications):_____

_____

Provider Signature:_____ Date:_____

Thank you for working with us to provide services to our EAP Works clients!