

NYS EAP Assessment Guidelines

FIRST remind the client that all information will remain confidential with the following exceptions (1) if there is a violation of law, executive order, or agency work rule; 2) If there is concern about imminent harm to self or others; (3) if there is reasonable suspicion of child abuse or neglect. **Assure the client that any notes taken will be destroyed in their presence and are taken only to aid in the assessment process.**

Self-Referred Client

- What concerns brought you to EAP?

- What needs to come out of this meeting so that you can say this was helpful?

- What have you done to try and resolve your concerns?

- What would it take for you to overcome this problem?

Referred Client

- Who referred you to EAP?
 - Supervisor
 - Union Representative
 - Family Member
 - Coworker
 - Other _____

- If you have been referred for a performance problem is it for
 - Absenteeism/Tardiness
 - Safety
 - Work Relationships
 - Quantity/Quality of Work
 - Other _____

- What will convince _____ that you don't need to see me?

- What does _____ expect to come out of your coming to EAP?

- Are you here as a result of a disciplinary settlement?

Health Information

- Do you have health insurance? If so, name of plan _____

- Date of last physical exam

- Current medical conditions

- Current medications

- Any sleep problems? Diet problems?

- Any history of emotional problems?

If "yes", how was it treated? Any complications?

Risk Assessment

- Have you thought about killing or hurting yourself or someone else? past present
- Suicidal Risk:
 - Intent
 - Plan
 - Means
 - Attempt
- Homicidal Risk:
 - Intent
 - Plan
 - Means
 - Attempt
- Domestic Violence:
 - Do you ever feel unsafe at home?
 - Are you in a relationship in which you have been physically hurt or felt threatened?
 - Have you ever been or are you currently concerned about harming your partner or someone close to you?

Work Situation

Home Situation (including any caregiver situation)

Support System

Relevant Legal History

Financial Concerns (including frequency of gambling)

Grief/Loss Issues (including any recent grief/loss)

Alcohol/Substance Use

- Do you use alcohol or drugs?
- On average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you had on any given occasion during the last month?

C – Have you ever felt the need to **CUT DOWN** on your drinking and/or drug use?

A – Have you ever been **ANNOYED** by criticism of your drinking and/or drug use?

G – Have you ever felt **GUILTY** about your drinking and/or drug use?

E – Have you ever felt the need for an **EYE OPENER** (alcohol/drugs) first thing in the morning to steady your nerves, i.e. to be able to function at work or at home, or to get rid of a hangover?

One or more positive responses indicate probable abuse or dependence. Refer for formal evaluation.

Family History of Alcohol/Drug Abuse or Mental Illness

Other

Is there anything that I haven't asked you that you think might be useful for me to know in helping you