Employee Assistance

Behavioral Health Programs

gup & ASSOCIATES, INC.

INITIAL CONTACT FORMS

PART I

PERSONAL INFORMATION:

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Can messages be left at this number? _____Yes _____No

Work Phone: _____ Can messages be left at this number? _____Yes _____No

Email: _____ Can messages be forwarded here? _____Yes _____No

Age: _____ Date of Birth: _____

Referred By: _____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship to you: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

WORK AND EDUCATION:

Present Occupation/Year in School: _____

Total hours/week: _____

Employer/School: _____

Address: _____

City: _____ State: _____ Zip: _____

PART II

INFORMATION QUESTIONARE:

Highest Level of Education: _____

Last school attended: _____

Are you currently enrolled in school? _____ _____Yes _____No

If so, where and what is your course of study? _____

_____

Relationship Status: _____ Single _____ Married _____ Divorced _____ Co-habiting

_____ Same-sex Partner _____ Dating _____ Widow/Widower

(If applicable) How long have you been in your present relationship?

_____

_____

Please list the people currently living with you and their relationship to you:

_____

_____

_____

_____

Do you have any children? _____Yes _____No

Do you have any pets? _____Yes _____No

If so, please list their names and ages below:

_____

_____

_____

_____

Describe any illnesses, injuries, or operations you have had (please include dates):

_____

_____

_____

Please list any mental health professional you have consulted in the past:

_____

_____

Name:_____

Problems: _____

Addressed:_____

Dates of Treatment: _____

What medications or special diets are you currently using?

_____

_____

_____

_____

Have any relatives been treated for any serious medical, emotional or substance abuse problems?

_____

_____

_____

_____

Do you have any limiting physical or intellectual conditions?

_____

_____

_____

_____

Briefly describe the problem which prompted you to seek counseling at this time.

_____

_____

_____

_____

_____

_____

_____

How have you addressed this issue thus far?

_____

_____

_____

_____

Are there any other professional persons (physicians, clergy, school personnel, law enforcement personnel, etc.) familiar with your current difficulties? If so, please list.

_____

_____

_____

_____

What would you like to be different in your life as a result of therapy?

_____

_____

_____

_____

Do you have any hobbies or special interests?

_____

_____

_____

_____

What do you do for relaxation and recreation?

_____

_____

_____

_____

How do you cope with stress?

_____

_____

_____

_____

Are you currently involved in any legal proceedings (divorce, custody hearings, civil suit, pressing criminal charges, being charged with a crime or misdemeanor, etc.)? _____Yes _____No

If yes, please explain briefly:

_____

_____

Do you anticipate any such involvement in the near future? _____Yes _____No

Do you smoke? _____No _____Yes How much? _____

Do you drink? _____Not at all _____Social _____Alone How much? _____

Do you use marijuana? _____ Not at all _____ Social _____Alone How much? _____

Do you use cocaine? _____No _____Yes How much? _____

Do you use other substances? _____No _____Yes What? _____

How much? _____

Is there anything else that you feel is important and that you would like for me to know?

_____

_____

_____

_____

_____

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items which are most important. (You may add comments after areas checked.)

____ Anger

____ Anxiety

____ Depression

____ Education/school problems

____ Eating difficulties

____ Fearfulness

____ Financial problems

____ Health concerns

____ Marital concerns

____ Problems with partner/significant other

____ Problems with children

____ Problems with parents

____ History of physical abuse

____ History of verbal/emotional abuse

____ Victim of crime or assault

____ Religious/Spiritual concerns

____ Sexual concerns

____ Sexual orientation

____ Thoughts of suicide

____ Trouble making decisions

____ Unhappy most of the time

____ Use of alcohol/drugs

____ Use of alcohol/drugs by significant other

____ Thoughts of harming someone

____ Vocational goals

____ Workplace issues

____ History of sexual abuse

____ Substance abuse by parent or guardian

____ Other (please specify) _____

_____

Fill out this form electronically or by hand and EMAIL to drgup@gupinc.com