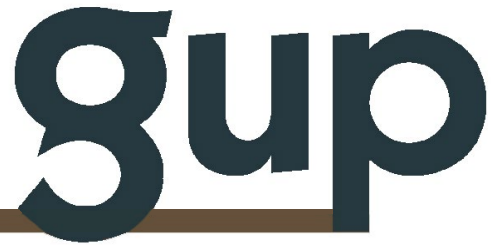


Employee Assistance

Behavioral Health Programs



& 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 QUESTIONNAIRE:

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.)

- | | |
|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Victim of crime or assault |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Religious/Spiritual concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Education/school problems | <input type="checkbox"/> Sexual orientation |
| <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Health concerns | <input type="checkbox"/> Use of alcohol/drugs |
| <input type="checkbox"/> Marital concerns | <input type="checkbox"/> Use of alcohol/drugs by significant other |
| <input type="checkbox"/> Problems with partner/significant other | <input type="checkbox"/> Thoughts of harming someone |
| <input type="checkbox"/> Problems with children | <input type="checkbox"/> Vocational goals |
| <input type="checkbox"/> Problems with parents | <input type="checkbox"/> Workplace issues |
| <input type="checkbox"/> History of physical abuse | <input type="checkbox"/> History of sexual abuse |
| <input type="checkbox"/> History of verbal/emotional abuse | <input type="checkbox"/> Substance abuse by parent or guardian |

Other (please specify) _____

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