Workplace Wellness

STANISLAUS COUNTY EMPLOYEE ASSISTANCE PROGRAM
1321 I Street ▪ Suite 3 ▪ Modesto, CA 95354 ▪ Phone (209) 558-8466

TODAY'S DATE:______________________________

NAME: ____
Last First Middle Maiden

OTHER NAMES USED:____

ADDRESS: ____
Street / P.O. Box City State Zip County

PHONE: (Home) ____________________ (Work) __________________________ (Other) ______________________

BIRTHDATE:______________________ AGE:________ EDUCATION:______________________________

CULTURAL/ETHNIC DESIGNATION:____
(How do you identify yourself with regard to Culture & Ethnicity)

SEX (Please ✓ one): ☐ Male ☐ Female

RELATIONSHIP STATUS (Please ✓ one): ☐ Single ☐ Living Together ☐ Separated ☐ Divorced ☐ Widowed ☐ Married

English speaking? ☐ Yes ☐No Do you prefer to discuss your situation in a language other than English? ☐ Yes ☐ No

PLACE OF EMPLOYMENT/DEPARTMENT (If client is a child, parent's place of employment/department): ______________________

REFERRED BY (Please ✓ one): ☐ Self ☐ Supervisor ☐ Other

Name of Supervisor or Other Referral Source:____________________ Name of Health Coverage:______________________

FAMILY MEMBERS OR SIGNIFICANT OTHER LIVING AT HOME:

Name	Age	Relationship

Have you had counseling before? If so, whom did you see and when? ______________________________

NAME OF PHYSICIAN(S)____________________________________DATE OF LAST VISIT:____________________

REASON FOR VISIT:____

IF CLIENT IS UNDER 18 YEARS OLD: Name of Parent or Guardian: ______________________________

School: ______________________________ Grade: ________ Primary Teacher: ______________________

NOTIFY IN CASE OF EMERGENCY: ______________________________ RELATIONSHIP: ____________________

ADDRESS: ____PHONE (Home/Work): ____________________

STATE NATURE OF PROBLEM:____

____

____

Have you recently experienced the following? (Please type or write in an X to all that apply)

SYMPTOM	NO	YES Occasionally (Weekly to Monthly)	YES Frequently (Daily to Weekly)	If yes, how long have you felt this way?
1. Depressed mood.				
2. Loss of pleasure, interest or increased apathy in activities you usually enjoy.				
3. Indecisiveness or decreased concentration.				
4. Trouble falling asleep or staying asleep.				
5. Sleeping most of the time.				
6. Weight loss or gain when not dieting.				
7. Fatigue or loss of energy.				
8. Recurrent thoughts of death.				
9. Physical agitation.				
10. Moving and thinking slower than usual.				
11. Feelings of worthlessness or inappropriate guilt.				

Have you recently experienced the following?

SYMPTOM	NO	YES Occasionally (Weekly to Monthly)	YES Frequently (Daily to Weekly)	If yes, how long have you felt this way?
1. Excessive anxiety or worry.				
2. Sudden periods of intense fear or panic.				
3. Accelerated heart rate.				
4. Difficulty breathing.				
5. Chest pain or discomfort.				
6. Numbness, tingling, hot flashes or chills.				
7. Difficulty swallowing or choking.				
8. Muscle tension.				
9. Trembling or shaking.				
10. Nausea or abdominal distress.				
11. Feeling “keyed up” or “on edge”.				
12. Intensely fearful thoughts of dying, “going crazy,” having a heart attack, stroke, cancer or other serious illness.				
13. Feelings that your body or world is unreal.				
14. Periods of time that you cannot remember or account for.				
15. Repetitive, intrusive thoughts and/or having to repeat specific behaviors.				
16. Racing thoughts.				
17. Unexplained periods of high energy and/or feelings of euphoria.				
18. Emotional turmoil – rapid changes in mood.				
19. Recurrent memories, dreams or nightmares of past, fearful events.				
20. Excessive concerns about your health.				

Workplace Wellness Survey continued

List any allergies to food, medications, or drugs. ______________________________

____

List any special diet that you subscribe to. ______________________________

____

Do you have any physical ailments (i.e. asthma, diabetes, cancer, etc.)? ______________________________

____

List all of the current medications, herbs, or drugs that you take (please include dosage). ______________

____

____

____

List, if any, medications, herbs, or drugs have you taken in the past for emotional reasons.______________

____

______________________________Do you feel that you have a problem with using or abusing alcohol, drugs, or medications?

☐ Yes ☐ No

Does someone in your life think that alcohol, drugs, or medications are a problem for you?

☐ Yes ☐ No

Are you currently attending any alcohol or drug treatment or support groups?

☐ Yes ☐ No If so, please list ______________________________

Is there anything you consider important about you that we need to know? ☐ Yes ☐ No

If so, please list if you feel comfortable ______________________________

____

Remember, all responses are kept completely confidential, except in certain legally mandated situations your counselor will talk to you about.