PARKVIEW
EMPLOYEE ASSISTANCE PROGRAM

# SELF-APPRAISAL FORM

**To be completed by client *(or parent/guardian if client is a minor).***

What is the primary problem as you see it? _____

_____

What secondary problems have resulted? _____

_____

On the scale below, please check the severity of the problem(s):

❑ Mildly Upsetting ❑ Moderately Upsetting ❑ Severe ❑ Extremely Severe ❑ Totally Incapacitating

Who have you previously consulted about your present problem(s)?

_____

Have you had any other previous counseling or therapy for other problems? ❑ Yes ❑ No
If yes, please discuss or describe: _____

_____

Describe any difficulties (if any) currently being experienced in your personal/family life:

_____

_____

Have you had any past experiences that distressed you then and/or currently? ❑ No ❑ Yes

With whom do you currently live? _____ For how long? _____

**JOB**

Are you satisfied with your current job or career path? ❑ Yes ❑ No

What problems do you perceive about your job? Please check all that apply

❑ Not Affected ❑ Performance Decline ❑ Absenteeism ❑ Disciplinary Action
❑ Impaired ❑ Tardy ❑ Conflict with peers
❑ Conflict with supervisor ❑ Unable to work ❑ Terminated ❑ Other

Specific details: _____

_____

Are you on a leave of absence: ❑ Yes ❑ No If yes, how long? _____

**FINANCIAL**

Primary source of income: _____

Are you experiencing financial stressors: (please be specific):

_____

_____

**HEALTH**

List any medical problems/disabilities: _____

_____

**NUTRITIONAL CONCERNS** (if any)

_____

**EMOTIONAL HEALTH**

Are you receiving treatment? (note type, duration, medication) _____

_____

_____

Family problems with drugs, alcohol, emotional/physical problems: _____

_____

_____

**DRUG USE**

Have you used non-medical drugs? ❑ Yes ❑ No If yes, what kinds? _____

_____

How frequently do you use them? _____

Do you use tobacco of any kind? ❑ Yes ❑ No If yes, what kinds and how much per day?

_____

Do you drink coffee? ❑ Yes ❑ No How much per day? _____

Do you drink cola or soft drinks? ❑ Yes ❑ No How much per day? _____

Have you ever abused prescription drugs? If so, please explain: _____

Have you ever overly used diet pills, laxatives, forced vomiting, or experienced binge eating? ❑ Yes ❑ No

If yes, please explain: _____

Do you drink alcohol? ❑ Yes ❑ No How much/how often? _____

**LEGAL**

Please note any current legal difficulties: (be specific): _____

_____

_____

**BELIEF SYSTEM**

Do you consider yourself to be a religious/spiritual person? ❑ Yes ❑ No Helpful? ❑ Yes ❑ No

Involvement level: ❑ Frequent ❑ Occasional ❑ Seldom ❑ Past only

**Please check any of the following which apply to you:**

| | | | |
|---|---|---|---|
| ❑ Headaches | ❑ Dizziness | ❑ Palpitations | ❑ Aggressive |
| ❑ Stomach trouble | ❑ No appetite | ❑ Fatigue | ❑ Guilty |
| ❑ Insomnia | ❑ Nightmares | ❑ Depressed | ❑ Deformed |
| ❑ Feel tense | ❑ Feel panicky | ❑ Overambitious | ❑ Full of regrets |
| ❑ Suicidal ideas | ❑ Anxious | ❑ Unable to relax | ❑ Inadequate |
| ❑ Sexual problems | ❑ Shy with people | ❑ Can't make friends | ❑ Agitated |
| ❑ Don't like weekends or vacations | | ❑ Indecisive | ❑ Bored |
| ❑ Memory problems | ❑ Hopeless | ❑ Concentration difficulties | |
| ❑ Financial problem | ❑ Racing thoughts | ❑ Feel slowed down | |
| ❑ Over sleeping / hypersomnia | | ❑ Worthwhile | |
| ❑ Worthless | ❑ Life is empty | ❑ Incompetent | |
| ❑ Intrusive thoughts | ❑ Attractive | ❑ Assertive | |
| ❑ Overeating | ❑ Misunderstood | ❑ Confused | |
| ❑ Intelligent | ❑ Considerate | ❑ Useless | |
| ❑ Naïve | ❑ Evil | ❑ Hostile | |
| ❑ Panicky | ❑ Unattractive | ❑ Lonely | |
| ❑ Non-confident | ❑ Other: | | |
| ❑ Trauma | ❑ Claims loneliness | ❑ | |
| ❑ Non-confident | ❑ Other: | | |

| **Trouble managing use of:** |
|---|
| ❑ Gambling |
| ❑ Pornography |
| ❑ Shopping / Spending |
| ❑ Gaming |
| ❑ Social media |