

Employee Resource Systems, Inc.

Client Data Form

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Client Name _____ ERS File # _____

Risk Factors (SI/HI, Domestic Violence, Sexual Abuse) _____ Low _____ Medium _____ High _____ No Risk

Safety plan _____

Substance Abuse/Addiction(s)

Onset _____

Pattern _____

Duration & frequency _____

Family Hx _____

Current Use _____

Additional or Contributing Issues

Academic/Employment

Living/Social Situation

Health/Medical

Family/Relationships

Financial/Legal

Other

Details _____

Psychiatric/Psychological

Current Signs and Symptoms

0 = None

1 = Mild (Impacts quality of life but no significant impairment of day-to-day functioning.)

2 = Moderate (Significant impact on quality of life and/or day-to-day functioning.)

3 = Severe (Profound impact on quality of life **AND** day-to-day functioning.)

Depressed Mood	0 1 2 3	Irritability	0 1 2 3	Tangential	0 1 2 3
Appetite Disturbance	0 1 2 3	Anxiety	0 1 2 3	Loose Assoc.	0 1 2 3
Sleep Disturbance	0 1 2 3	Panic Attacks	0 1 2 3	Delusions	0 1 2 3
Low Energy/Fatigue	0 1 2 3	Phobias	0 1 2 3	Hallucinations	0 1 2 3
Psychomotor Retardation	0 1 2 3	OCD	0 1 2 3	Aggressive	0 1 2 3
Poor Concentration	0 1 2 3	Eating Disorder	0 1 2 3	Conduct Dis.	0 1 2 3
Agitation	0 1 2 3	Paranoia	0 1 2 3	ADHD	0 1 2 3
Lability	0 1 2 3	Sex Dysfunction	0 1 2 3	Other	_____

Prior treatment history _____



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Client Name _____ ERS File # _____ Session Date _____

Session # _____ Clinical Impressions _____

Rationale/Recommendation for next session

Additional EAP sessions

Recommendation at case closing

Clinician's Signature _____ Date _____

Session Date _____ Session # _____

Clinical Impressions _____

Rationale/Recommendation for next session

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