MERCY EMPLOYEE ASSISTANCE PROGRAM- *C.D., Medical, Psych History, Risk, Legal*

Client Name_____ Date_____

Chemical Usage	**Type**	**Age started**	**Amt/Frequency**	**Last Use**
Alcohol				
Marijuana				
Cocaine/Crack				
Amphetamines				
Other				

Are you experiencing withdrawal? □ No □ Yes _____

Addictions

Gambling				
Other				

Risk Assessment :

Suicide Ideation	□ No □ Yes	If yes, explain:
Homicidal Ideation	□ No □ Yes	If yes, explain:
Thoughts of Violence	□ No □ Yes	If yes, explain:

Legal Issues:	□ No □ Yes	If yes, explain:

Functional Impairment Scale:	**0= Absent**	**1= Mild**	**2= Moderate**	**3= Severe**
		Initial		**At Closure**
Anger/Agitation		0 1 2 3		0 1 2 3
Hyperactivity		0 1 2 3		0 1 2 3
Sleep		0 1 2 3		0 1 2 3
Appetite		0 1 2 3		0 1 2 3
Mania		0 1 2 3		0 1 2 3
Depression		0 1 2 3		0 1 2 3
Anxiety		0 1 2 3		0 1 2 3
Obsessive Compulsive Disorder		0 1 2 3		0 1 2 3
Eating Patterns (binge, anorexia)		0 1 2 3		0 1 2 3
Psychotic Process		0 1 2 3		0 1 2 3
Cognitive Process		0 1 2 3		0 1 2 3
Psycho/Social Relationships		0 1 2 3		0 1 2 3

Current Medical Conditions: _____

Medical/Psychiatric History: _____

Current Medications: _____

History of C.D. Treatment:

Have you been hit, slapped, kicked, choked, or otherwise physically hurt by someone in the past year? □ No □ Yes If yes, explain: _____

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