

Strong EAP Pre-Screening Survey

DATE \_\_\_\_\_

Case \_\_\_\_\_  
Number \_\_\_\_\_

- **Individual information provided is confidential.**

**1. How would you best describe the reason *you chose* to contact Strong EAP? (check only one)**

- A work-related problem that **is not** impacting my personal life
- A work-related problem that **is** impacting my personal life
- A personal problem that **is not** impacting my work performance
- A personal problem that **is** impacting my work performance

**2. Is your problem *impacting your work performance*, if so, please check the most appropriate answer:**

- Resulted in the use of sick time
- Resulted in decreased work productivity
- Resulted in decreased effectiveness in work role
- Other (Please specify):  
\_\_\_\_\_

**3. During the last four weeks, how much difficulty have you had doing your work or other regular daily activities as a result of your *physical health*?**

- None at all
- A little bit
- Some
- Quite a bit
- Could not do daily work

**4. During the last four weeks, to what extent have you accomplished less than you would like in your work or in other daily activities as a result of *emotional problems* (such as feeling depressed or anxious)?**

- None at all
- Slightly
- Moderately
- Quite a bit
- Extremely

**5. During the last four weeks, to what extent have your physical health or emotional health problems interfered with your normal *social activities* with family, friends, neighbors, or groups?**

- None at all
- Slightly
- Moderately
- Quite a bit
- Extremely

**6. During the last four weeks, to what extent have your physical health or emotional health problem interfered with your *relationship with your co-workers* or supervisor?**

- None at all
- Slightly
- Moderately

Quite a bit  
Extremely

7. Which of the following best describes the specific reason why you sought EAP services? (Check all that apply)

Feeling Depressed/Anxious  
Marital/Relationship Difficulties  
Self-Esteem Difficulties  
Academic Problems  
Work-Related Problems  
Sexual Difficulties  
Career Issues  
Legal Issues

A work-site critical incident  
Other traumatic experience (rape, abuse, accident, etc.)  
Loss of Loved One/Grief  
Concerns about Alcohol/Drug Use  
Family/Parent-Child Issues  
Physical/Medical Problem  
Financial concern  
Other (Please specify): \_\_\_\_\_

**Yes**                      **No**

8. Was your call to Strong EAP answered in a prompt manner? \_\_\_\_\_

9. Was an appointment arranged in a timely fashion? \_\_\_\_\_

10. Would you have taken time off from work to deal with your concerns if Strong EAP were not available? \_\_\_\_\_

11. If you did not have Strong EAP available to you, where would you go to seek assistance?

Family member/Friend  
Supervisor/Co-worker  
Professional contact in the community  
Primary care physician  
Other (Please specify: \_\_\_\_\_ )  
I would not know where to go to seek assistance

12. How many times have you been unexpectedly absent or tardy in the last 30 days due to physical or mental health reasons? \_\_\_\_\_

13. The following is a list of general physical symptoms that people may experience. Please check all that apply to your experience over the past 1-4 weeks:

- |   |   |
|---|---|
| Repetitive, senseless thoughts/behaviors    | Increase or decrease in weight          |
| Sad/depressed/down in the dumps             | Helpless feelings                       |
| Tremors, trembling or shakiness             | Frequent crying or weeping              |
| Violent behavior                            | Frequent thoughts of death or suicide   |
| Constant worry/Fear                         | Worthless feelings                      |
| Irritability                                | Hopeless feelings                       |
| Tension/Nervousness/Agitated                | Lack of/loss of interest in things      |
| Feeling in a dreamlike state                | Feeling life is not worth living        |
| Concentration Difficulties/Memory problems  | Decrease in sex drive                   |
| Sweating                                    | Frequent negative thinking              |
| Dizziness/lightheadedness                   | Fear of dying                           |
| Insomnia/trouble sleeping/sleeping too much | Seeing/hearing things that are not real |
| Fear of going crazy or losing control       | Fatigue – lack of energy                |



**14. Which of these life events have influenced your well-being during the last 4 weeks. [Please check all that apply]**

<u>OCCUPATIONAL</u>	<u>FINANCIAL</u>	<u>RELATIONSHIP</u>
New job	Recent financial demands	Difficulty with significant other
Job difficulties	Outstanding bills	Difficulty with friend or relative
Job loss	Loan(s)	New relationship
Interpersonal problems at work	Completion of a loan or mortgage	Marriage
Pay raise	Taking out a mortgage	Divorce
Change of job status or responsibilities	Loss of money	Marital separation
Change of hours at work	Recent financial gain	Breakup of relationship
Change of conditions at work	Other:	Death of a relative or friend
Positive job review	[Redacted]	Sexual difficulties
Negative job review		Major life event of friend, family, or significant other
Retirement		Household member leaving home
Change of job status of a household member		Pregnancy
Other:		Pregnancy-related issues
		Birth of a child
		Other: _____

<u>PERSONAL</u>	<u>SCHOOL</u>	<u>SOCIAL</u>
Personal injury	Beginning of new session	Vacation
Personal illness	End of session	Holiday
Illness or injury of a family member	Exam	Recreational activity
Problems with the law	Change of school	Family get-together
Change of a personal habit	Positive achievement	Religious activity
Personal achievement	Negative achievement	Social event
Other: _____	Other: _____	Other: _____