

Colorado state professional disclosure for: Lloyd Davis, MA, LPC, CEAP

- License, certificate, and degree held
- Licensed professional counselor Colorado state license #194
- Masters of arts in counseling from Adams State College
- ThD in counseling from Christian Bible College and Seminary
- Certified employee assistance professional
- Substance abuse professional

State law requires disclosure of much of this material, but I hope it will also help you to be an educated consumer of EAP/counseling services, or those of any other mental health professional.

The practice of psychotherapy is regulated in Colorado whether the provider is licensed or unlicensed. The Colorado Department of Regulatory Agencies has this responsibility and they offer the services of a state grievance board. You may visit or contact them at 1560 Broadway, Suite 1340, Denver, Colorado 80202, (303) 894-7766.

You are entitled to know what you are getting in counseling. Ask anything you wish about my training and qualification, what methods I may use, how long I think it may take to reach the goals we agree upon, and what the fees are (for EAP services – there are no fees). Please do not hesitate to question or challenge me. Your honesty will only help me do my job better. You may seek a second opinion; you may fire me at any time. I also may suggest that you get a second opinion, and I too have the right to terminate the relationship if I believe my services are not benefiting you.

Sexual intimacy between a mental health provider and a client (regardless of age) is unethical and illegal, and should be reported to the grievance board.

The information you or your family members provide to me during our sessions is legally confidential, which means I am not free to disclose it to anyone else without your permission. Often children or teenagers ask, "What are you going to tell my parents?" or parents ask, "What did my child say?" My policy is never to promise full confidentiality to young people, but rather to use careful judgment in passing information back and forth and to be as clear as possible in explaining to the child what I wish to share with the parents. Please let me know if you have concerns about what you are hearing or not hearing from me.

There are exceptions to the confidentiality rule, which include giving warning about:  
a client who presents a danger to self or others,  
suspected child abuse, or  
a client who files suit against me.

I will alert you if any legal exceptions to confidentiality arise in our sessions. Most often, keeping this confidential from those outside our professional relationship is not a problem.

Please feel free to clarify any questions you may have concerning this information.

I look forward to working with you.

Signature acknowledges client received a copy.

Client: \_\_\_\_\_

Date: \_\_\_\_\_

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# Employee Assistance Program (EAP)

## Questionnaire for EAP Services Adult Kit

The following information will help us serve you better and to evaluate the effectiveness of the EAP. All information will remain strictly confidential as prescribed by law and the policy of the EAP.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ M \_\_\_\_\_ F

SS#: \_\_\_\_\_

Telephone Numbers:

Home: \_\_\_\_\_  okay to call/leave message

Work: \_\_\_\_\_  okay to call/leave message

Cell: \_\_\_\_\_  okay to call/leave message

Other: \_\_\_\_\_  okay to call/leave message

E-mail Address: \_\_\_\_\_

Marital Status:

Married  Divorced

Partnered  Separated

Single  Widowed

In order to better serve you, the EAP program conducts anonymous follow-up surveys.

May we contact you by mail?  Yes  No

How were you referred to the Employee Assistance Program? Please circle as appropriate:

Co-worker  Physician or health service

Global e-mail  Human resources

Pastoral care  Poster

Employee health  Brochure

Family member  Friend

Orientation  Supervisor

Self  Other: \_\_\_\_\_

Counselor

Please provide the following employee information:

Name: \_\_\_\_\_

Employer:

Hilltop

Community

Other: \_\_\_\_\_

Shift:

Full Time

Part Time

PRN/Casual

# Employee Assistance Program (EAP)

## Questionnaire for EAP Services Adult Kit (con't)

Job title: \_\_\_\_\_

Relation to employee:

- Self  
 Spouse  
 Dependent

Reason for today's appointment: (Please mark in order #1 #2 #3 etc.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Panic attacks             | <input type="checkbox"/> Substance use/abuse     |
| <input type="checkbox"/> Personal issues     | <input type="checkbox"/> Addictions                | <input type="checkbox"/> Anger                   |
| <input type="checkbox"/> Bereavement         | <input type="checkbox"/> Depression                | <input type="checkbox"/> Disability              |
| <input type="checkbox"/> School              | <input type="checkbox"/> Sexuality                 | <input type="checkbox"/> Stress                  |
| <input type="checkbox"/> Suicidal            | <input type="checkbox"/> Work related issues       | <input type="checkbox"/> Management issues       |
| <input type="checkbox"/> Stress              | <input type="checkbox"/> Work injury               | <input type="checkbox"/> Trauma                  |
| <input type="checkbox"/> Family issues       | <input type="checkbox"/> Parent-Child difficulties | <input type="checkbox"/> Pre-Marriage counseling |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Medical/Dental issues     | <input type="checkbox"/> Financial issues        |
| <input type="checkbox"/> Custody issues      | <input type="checkbox"/> Other: _____              |  |

Work-related impact of problem:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Poor relationships | <input type="checkbox"/> Poor communication  |
| <input type="checkbox"/> Tardiness   | <input type="checkbox"/> Tired              | <input type="checkbox"/> Motivation          |
| <input type="checkbox"/> Discontent  | <input type="checkbox"/> Stress             | <input type="checkbox"/> Disciplinary status |

Name of primary care physician: \_\_\_\_\_

List all medications you are currently taking:

_____	_____
_____	_____
_____	_____

Please describe any physical/health problems or concerns:

_____	_____
_____	_____
_____	_____

How would you rate the general state of your health?

- Excellent       Good       Fair       Poor

Are you under the care of a mental health provider?

- Yes       No

If yes, please provide name(s): \_\_\_\_\_

Reason: \_\_\_\_\_

Have you seen other professionals for today's problem?

- Yes       No

If yes, please provide name(s): \_\_\_\_\_

# Employee Assistance Program (EAP)

## Questionnaire for EAP Services Adult Kit (con't)

Do you have any history of traumatic life experience or emotional trauma such as physical/sexual abuse, neglect, domestic violence, etc.?  Yes  No

If yes, please list:

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Do you have any children?  Yes  No

If yes, please provide name(s) and age(s):

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Are there any family concerns that you have – childhood through present?  Yes  No

How would you rate the following:

Your exercise program:  Excellent  Good  Fair  Poor

Your diet and nutritional habits:  Excellent  Good  Fair  Poor

Your social relationships:  Excellent  Good  Fair  Poor

Are you concerned about possible violence at work?  Yes  No

Are you concerned about possible violence in your personal life?  Yes  No

Are there any drug or alcohol issues we should be aware of?  Yes  No

History of alcohol or drug abuse in your immediate family?  Yes  No

History of alcohol or drug abuse in your family of origin?  Yes  No

History of depression/suicide in your family?  Yes  No

History of depression/suicide in your family of origin?  Yes  No

If EAP services were not available, would you have sought assistance through your health insurance benefit?

Yes  No

Religious preference: \_\_\_\_\_

Name of church: \_\_\_\_\_

Is there anyone you would like me to talk to regarding your treatment or to gain further information?

Yes  No

If yes, please provide name(s): \_\_\_\_\_

# Employee Assistance Program (EAP)

## Questionnaire for EAP Services Adult Kit (con't)

Please check all that apply to you:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Panic attacks                        | <input type="checkbox"/> Performing unusual rituals of habits       |
| <input type="checkbox"/> Low energy                             | <input type="checkbox"/> Heart racing                         | <input type="checkbox"/> Impulsiveness                              |
| <input type="checkbox"/> Low self-esteem                        | <input type="checkbox"/> Chest pain or heaviness              | <input type="checkbox"/> Poor concentration                         |
| <input type="checkbox"/> Chills/hot flashes                     | <input type="checkbox"/> Excessive behaviors                  | <input type="checkbox"/> Lack of interest or enjoyment              |
| <input type="checkbox"/> Tingling/numbness                      | <input type="checkbox"/> Delusions or hallucinations          | <input type="checkbox"/> Feeling hopeless                           |
| <input type="checkbox"/> Pain                                   | <input type="checkbox"/> Sexual problems or behaviors         | <input type="checkbox"/> Feeling worthless                          |
| <input type="checkbox"/> Fear of dying                          | <input type="checkbox"/> Self injurious behaviors             | <input type="checkbox"/> Feeling guilty or shameful                 |
| <input type="checkbox"/> Fear of going "crazy"                  | <input type="checkbox"/> Shyness                              | <input type="checkbox"/> Sleep changes                              |
| <input type="checkbox"/> Nausea                                 | <input type="checkbox"/> Lack of Social skills                | <input type="checkbox"/> Loneliness                                 |
| <input type="checkbox"/> Fears of Phobias                       | <input type="checkbox"/> Lack of Social support               | <input type="checkbox"/> Bad dreams or nightmares                   |
| <input type="checkbox"/> Obsessions or compulsions              | <input type="checkbox"/> Stealing                             | <input type="checkbox"/> Feeling ignored or abandoned               |
| <input type="checkbox"/> Thoughts racing                        | <input type="checkbox"/> Strange, weird, or peculiar behavior | <input type="checkbox"/> Appetite changes                           |
| <input type="checkbox"/> Disorganization                        | <input type="checkbox"/> Confusion or can't think clearly     | <input type="checkbox"/> Mood swings                                |
| <input type="checkbox"/> Procrastination                        | <input type="checkbox"/> Feeling "not real"                   | <input type="checkbox"/> Thoughts of hurting self                   |
| <input type="checkbox"/> Can't hold on to an idea               | <input type="checkbox"/> Feeling detached from yourself       | <input type="checkbox"/> Thoughts of hurting others                 |
| <input type="checkbox"/> Anger or frustration                   | <input type="checkbox"/> Feeling "hyper"                      | <input type="checkbox"/> Isolation from others or social withdrawal |
| <br>  |   |   |
| <input type="checkbox"/> Suspiciousness or mistrustfulness      | <input type="checkbox"/> Financial problems                   | <input type="checkbox"/> Feelings of sadness or loss                |
| <input type="checkbox"/> Problems trusting others               | <input type="checkbox"/> Grief/bereavement                    | <input type="checkbox"/> Weight problems                            |
| <input type="checkbox"/> Easily irritated or annoyed            | <input type="checkbox"/> Health problems                      | <input type="checkbox"/> Stress                                     |
| <input type="checkbox"/> Aggressiveness                         | <input type="checkbox"/> Problems impact others               | <input type="checkbox"/> Anxiety, tension or worry                  |
| <input type="checkbox"/> Perfectionist behavior                 | <input type="checkbox"/> Losing track of time                 | <input type="checkbox"/> Arguing with others                        |
| <input type="checkbox"/> Lying                                  | <input type="checkbox"/> School or educational problems       | <input type="checkbox"/> Making or keeping friends                  |
| <input type="checkbox"/> Bothered by recurring thoughts         | <input type="checkbox"/> Property destruction                 | <input type="checkbox"/> Self-criticism                             |
| <input type="checkbox"/> Family problems                        | <input type="checkbox"/> Marital problems                     | <input type="checkbox"/> Relationship problems                      |
| <input type="checkbox"/> Parent-child problems                  | <input type="checkbox"/> Use of alcohol                       | <input type="checkbox"/> Use of drugs                               |
| <input type="checkbox"/> Blackouts                              | <input type="checkbox"/> Physical abuse                       | <input type="checkbox"/> Sexual abuse                               |
| <input type="checkbox"/> Partner abuse                          | <input type="checkbox"/> Parent abuse                         | <input type="checkbox"/> Trouble with the law                       |
| <input type="checkbox"/> Unpleasant thoughts that won't go away |   | <input type="checkbox"/> Other:                                     |

I, \_\_\_\_\_ consent to the following EAP services

(check all that apply):

- Clinical Interview/Evaluation
- Counseling/Psychotherapy/Referral
- Other

Signature of person giving consent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness/EAP representative: \_\_\_\_\_ Date: \_\_\_\_\_