



90 DAY FOLLOW-UP

PATIENT # _____

NAME: _____ AGE: ____ MOM/DAD NAME _____

CITY: _____ EMPLOYER _____

PHONE: (H) _____ LM __ NO __ CONF __ (W) _____ LM__ NO __ CONF __

DID YOU HAVE PROBLEMS SCHEDULING APPOINTMENTS? YES NO

DID YOU HAVE SUFFICIENT INFORMATION REGARDING HOW TO CONTACT THE EAP? YES NO

WERE YOU SATISFIED WITH YOUR EAP THERAPIST? YES NO

REMARKS: _____

IF YOU WERE REFERRED TO ANYONE OUTSIDE THIS OFFICE, TO WHOM WERE YOU REFERRED?

WERE YOU SATISFIED WITH THAT THERAPIST? YES NO

HOW SATISFIED WERE YOU WITH THE PROGRAM?

EXTREMELY VERY MODERATELY SOMEWHAT NOT SATISFIED

HOW DO YOU FEEL ABOUT YOUR PROBLEM NOW?

MUCH IMPROVED SOME IMPROVEMENT NO CHANGE

SOMEWHAT WORSE MUCH WORSE

WHAT EFFECT DID THE EAP HAVE ON YOUR JOB PERFORMANCE?

IMPROVED UNCHANGED NOT APPLICABLE

WOULD YOU RETURN FOR EAP SERVICES? YES NO

REMARKS: _____

CAN WE BE OF ANY FURTHER ASSISTANCE AT THIS TIME? YES NO

REVIEWED BY _____ DATE _____

Please return this form to Matrix by mail or fax:

Matrix
Attn: follow-up
2 Easton Oval, Ste. 450
Columbus, OH 43219
Fax: 614/475-9821