
Workplace Wellness Questionnaire

Confidential Self-Assessment for Employees – Bridging the Gaps EAP

Instructions for Employees

This questionnaire is **voluntary and confidential**. Your responses help you reflect on your well-being and allow our EAP professionals to provide support if needed.

- Complete honestly; there are no right or wrong answers.
 - This questionnaire is **not a diagnostic tool**. It is intended to identify areas where additional support may be helpful.
 - If you have concerns about your health, please reach out to your EAP or a qualified professional.
-

Section 1: Stress & Emotional Health

Rate each statement based on your experiences in the past month.

Question	Never	Rarely	Sometimes	Often	Always
I feel stressed or overwhelmed at work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble focusing or concentrating on tasks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel anxious or worried during the workday.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty balancing work and personal life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel emotionally drained or fatigued at the end of the day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Physical Health & Well-Being

Question	Never	Rarely	Sometimes	Often	Always
I get adequate sleep most nights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I experience frequent headaches, muscle tension, or other physical symptoms of stress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I maintain a regular exercise routine or physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I eat balanced meals and stay hydrated during the workday.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take breaks to rest and recharge during work hours.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Workplace Behavior & Engagement

Question	Never	Rarely	Sometimes	Often	Always
I feel motivated and engaged in my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have noticed changes in my mood or behavior at work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I interact positively with coworkers and maintain healthy professional relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find myself withdrawing from colleagues or team activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have noticed an increase in errors or missed deadlines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 4: Substance Use (Optional)

This section is optional and **for self-reflection only**.

Question	Never	Rarely	Sometimes	Often	Always
I consume alcohol in a way that impacts my work or well-being.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have used prescription or over-the-counter drugs in ways not intended.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have used substances to cope with stress or work pressure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 5: Reflection & Support Needs

1. What areas of your wellness do you feel need the most attention?
(Text field for free response – fillable)
 2. Would you like to speak with an EAP professional about support or resources?
 - ☐ Yes
 - ☐ No
-

Optional Scoring & Interpretation for EAP Staff

- **Never/Rarely** = Low concern
- **Sometimes** = Moderate concern, monitor and offer resources
- **Often/Always** = High concern, consider EAP consultation or referral

Note: Employees' answers are confidential. Use responses only to guide voluntary support or wellness resources.