Client Information Form

All Points EAP & Organizational Services

1. Today's date _____

For Office Use:
Cons: Self / Sup

INSTRUCTIONS: Please complete these questions about yourself.

2. YOUR NAME: Last _____ **First / Middle Initial** _____

Previous last name (if applicable) _____ **3. Your Social Security #** _____

4. YOU ARE: ☐ Employee of covered organization ☐ Retiree ☐ Other organizational status _____

☐ Family member : __ Dependent, __Spouse, __ Other

5. Covered Employee's Name (if different from above) **Last / First / M.I.:** _____

Employee's Organization:_____ **Employee's Social Security #** _____

CONTACT INFORMATION:

6. Home phone # _____ **Okay to call?** ☐ Yes ☐ No **Okay to leave message?** ☐ Yes ☐ No

7. Work phone # _____ **Okay to call?** ☐ Yes ☐ No **Okay to leave message?** ☐ Yes ☐ No

8. Cell phone # _____ **Okay to call?** ☐ Yes ☐ No **Okay to leave message?** ☐ Yes ☐ No

9. E-mail address _____ **Is it okay to send you an e-mail?** ☐ Yes ☐ No

10. Home mailing address (street address, city, state & zip code)

_____

_____

11. Your Employer (if you are not the covered employee)

_____

Your Primary Care Physician: _____

12. Your Gender: ☐ Female ☐ Male

13. Date of birth _____ **Age** _____

14. Your Race/ Ethnic origin

☐ African American ☐ Asian/Pacific Islander
☐ Caucasian ☐ Hispanic/Latino
☐ Native American Indian ☐ Other race/ethnic origin (describe)

_____

15. Your current marital / relationship status

☐ **Married** (how long?) _____
☐ **Single/never married**
☐ **Separated** (how long?) _____
☐ **Divorced** (how long?) _____
☐ **Widowed** (how long?) _____
☐ **Other** (describe) _____

Is your spouse/other also a client today? ☐ Yes ☐ No

16. Names and ages of children (if any) **Also a client today?**

_____ Yes / No
_____ Yes / No
_____ Yes / No

17. Names, relationships and ages of other household members (if any – including **spouse/other**)

_____

_____

If any above are also a client today - list SS# & Date of Birth:

_____

_____

18. Your Highest level of education completed

☐ Elementary/middle school ☐ Bachelor's degree
☐ High school ☐ Master's degree
☐ Some college or tech school ☐ Doctoral degree
☐ Associate degree/technical degree

19. Are you covered by any health insurance plan?

☐ **Yes** (name of plan) _____
☐ **No**

Secondary Insurer? (name of plan) _____

INSTRUCTIONS: Employees please complete the following questions as they apply to yourself. Family members or dependents of covered employees complete these questions as they apply to the employee, if you know the information.

COVERED EMPLOYEE INFORMATION:

20. Covered Employee's Name

_____

21. Employer _____

22. Division or Department (if applicable)

_____

23. Work location (e.g., city, plant name)

_____

24. Employment status

☐ Full-time
☐ Part-time
☐ Temporary
☐ Other employment status (describe below)

_____

25. Job title/position

_____

26. Is this a safety-sensitive position?

☐ Yes
☐ No

27. Type of regulated position

☐ Not in a regulated position
☐ Department of Transportation **(DOT)**
☐ Department of Energy **(DOE)**
☐ Nuclear Regulatory Commission **(NRC)**

28. Work type

☐ Salaried: Exempt (overtime not paid)
☐ Salaried: Non exempt (overtime paid)
☐ Hourly

29. Occupation (check only one)

☐ **Manager** - official, executive, middle manager, supervisor
☐ **Professional** - engineer, teacher, lawyer, registered nurse, counselor
☐ **Technician** - programmer, medical technician, nuclear technician
☐ **Sales** - sales clerk, cashier, insurance agent, broker
☐ **Office/Admin Support** - secretary, bank clerk, HR assist., dispatchers
☐ **Skilled craft worker** - machinist, electrician, painter, mechanic
☐ **Machine/transport operator** - truck driver, plant operator, printing
☐ **Laborer** - factory hand, agricultural worker, construction laborer
☐ **Service worker** - police, firefighter, cook, janitor, jailor, healthcare
☐ **Other occupation** (describe below)

_____

30. Work Shift

☐ Do not work shifts
☐ Days / First
☐ Evenings / Second
☐ Nights / Third
☐ Swing
☐ Other shift (describe below)

_____

31. Number of years with current employer _____

32. Supervisor's Name _____

Is this your first time to the EAP? ☐ Yes ☐ No **If NO, when were you last seen? (approx.)** _____

How did you hear about the EAP?

Myself: ___Brochure, ___Newsletter, ___Paycheck Insert, ___Poster, ___ Presentation/Training, ___Website, ___I'm a Returning Client

☐ Family Member
☐ Coworker
☐ Supervisor / Manager
☐ Human Resources
☐ Medical Review Officer
☐ Employee Health / Company Medical Clinic
☐ Private Medical provider
☐ Other Referral Source (other than Work) _____

Name_____ Date_____

As part of your EAP assessment, please take a moment to provide us with the following information by briefly answering the questions below.

1. Briefly describe what brings you to EAP at this time?

_____

_____

2. Have you attempted to resolve this issue? If so, how?

_____

_____

3. Do you currently or have you ever had any significant medical illnesses, surgeries, or injuries (including head injuries)? If so, please list.

_____

_____

4. Are you on any current medications? If so, please list medications and prescribing doctor.

_____

_____

5. Have you ever seen a counselor or psychiatrist? If so, please list provider and the date that you were seen.

_____

_____

6. If you are currently employed, on a scale from 1 – 10 with 10 being the best you have ever performed on your job, how would you rate your current job performance?

_____

Symptoms Checklist:

Check all that apply if the person seeking help has had any of the following in the last couple months:

Physical and Mental

- ☐ Appetite change
- ☐ Headaches
- ☐ Fatigue
- ☐ Insomnia or sleep difficulties
- ☐ Weight change
- ☐ Pounding heart
- ☐ Teeth grinding
- ☐ Increased alcohol, drug, and/or tobacco use
- ☐ Forgetfulness / memory problems
- ☐ Poor concentration
- ☐ Low productivity
- ☐ Negative attitude
- ☐ Confusion
- ☐ Whirling / racing thoughts
- ☐ Difficulty making decisions
- ☐ Thoughts of harming self
- ☐ Thoughts of harming others

Emotional and Relational

- ☐ Anxiety
- ☐ Frustration
- ☐ Irritability
- ☐ Mood swings
- ☐ Crying spells
- ☐ Depression
- ☐ Worrying
- ☐ Guilt
- ☐ Anger
- ☐ Intolerance
- ☐ Resentment
- ☐ Lowered sex drive
- ☐ Distrust
- ☐ Loneliness
- ☐ Emptiness
- ☐ Loss of meaning or direction

Behavioral and Work/School

- ☐ Change in activity level
- ☐ Social withdrawal
- ☐ Unlawful acts
- ☐ Risk-taking behaviors
- ☐ Self injury
- ☐ Suicidal attempts
- ☐ Attempts to harm others
- ☐ Self induced vomiting or binging
- ☐ Less attention to appearance and/or hygiene
- ☐ Physical / sexual abuse
- ☐ Increased absenteeism
- ☐ Decrease in quality of work
- ☐ Erratic / disruptive behavior
- ☐ Tardiness
- ☐ Procrastination
- ☐ Negative attitude toward company or school

STATEMENT OF EAP SERVICES

All Points EAP & Organizational Services

To be read and signed by all clients age 14 and older

SERVICES and ELIGIBILITY ▪ Your employee assistance program (EAP) provides assessment, short-term consultation, referral, and follow-up to help resolve personal and work concerns. EAP is available to all eligible employees and their immediate family members.

FEES ▪ EAP is offered at no cost to you. If a referral for services outside of EAP is recommended, we will help you locate an appropriate resource. It is the client's responsibility to pay for any service(s) outside the EAP. Some outside services may not be medically necessary and therefore may not be covered by your insurance. We will work with you to clarify your benefits; however, it is your responsibility to verify insurance coverage and costs. Signing this agreement grants us permission to contact your insurance provider to coordinate benefits.

EAP may charge for court-related services (such as consultations with lawyers or attendance at court proceedings) as these are not standard EAP services. Please ask for more information if you believe this may apply to you.

CONFIDENTIALITY and RELEASE OF INFORMATION

Information acquired through EAP participation will not be given to anyone outside EAP without the client's consent, except as required or permitted by law or as described below:

- Suspected abuse of children or disabled adults is required to be reported to the Dept. of Social Services.
- Dangerous situations: EAP may disclose information to prevent harm to self, another person, or property, or if it appears that an illegal act or threat of such has been committed against the employer or EAP.
- Compliance with a court order.
- In couples/conjoint counseling, all parties may be required to consent to the release of confidential information.
- Holders of security clearances or other persons who are judged to be of danger to self, others or a threat to the security of the company or to national security.

SUPERVISOR / EMPLOYER REFERRALS ▪ If an employer refers an employee because of a work-related issue, EAP will confidentially advise the referral source regarding whether the employee kept the appointment. Except as otherwise discussed here, no further information will be released without the employee's consent. An employee's participation in the EAP is voluntary, unless his/her employer determines otherwise.

COMPLIANCE WITH EMPLOYER POLICIES, WORK RULES and STANDARDS ▪ Employees participating in the EAP should not expect any special privileges or exceptions to employer policies or practices. EAP participation does not affect management's right to take disciplinary measures nor does it interfere with the employee's right to use the grievance procedure within the framework of existing policies or agreements.

I have read this Statement of Understanding and understand its contents. I have also received a Notice of Privacy Practices.

Client signature(s) _____ Date _____

_____ _____

_____ _____

Witness _____ Date _____