CHI St. Alexius Health

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C I S

Employee Assistance Program

You are being asked to provide information which we believe is critical to your care. By completing the form, we will be better able to attend to your issues in the sessions. If you believe that an item does not apply or is confusing, please feel free to proceed to another item and discuss with your EAP counselor. **ALL INFORMATION REMAINS STRICTLY CONFIDENTIAL.**

Today's Date:

INFORMATION ABOUT PERSON USING THE EAP

Name	Date of Birth	Gender	Marital Status
	/ /	❑ Male ❑ Female	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Address			
City / State / Zip			

Home Telephone Number ( ) May we contact you at this number? ❑ Yes ❑ No

Cell/Mobile Phone Number ( ) May we contact you at this number? ❑ Yes ❑ No

Work Telephone Number ( ) May we contact you at this number? ❑ Yes ❑ No

Who referred you to EAP?
- ❑ Self
- ❑ Family Member
- ❑ Supervisor - Job Performance
- ❑ Supervisor - Personal Concern
- ❑ Other Employees
- ❑ Human Resources
- ❑ Friend
- ❑ Other

OTHER FAMILY MEMBERS IN YOUR HOUSEHOLD

Name	Date of Birth	Relationship
	/ /	
	/ /	
	/ /	

INFORMATION ABOUT EMPLOYEE WHO HAS EAP BENEFIT

The person using the EAP is:
❑ Employee ❑ Employee's Spouse ❑ Employee's Child ❑ Another Relative ❑ Other

1. Name of Employee	2. Date of Birth	3. Gender
	/ /	❑ Male ❑ Female

5. Name of Employer or Organization which provides this EAP benefit.

6. Year employee started

7. Does this employee supervise other employees? ❑ Yes ❑ No

4. Employee's Occupation is:
- ❑ Professional
- ❑ Admin/Mgmt
- ❑ Technician
- ❑ Sales
- ❑ Laborer
- ❑ Skilled Craft
- ❑ Clerical
- ❑ Operative/Maintenance

BRIEFLY DESCRIBE YOUR CONCERN:

ABOUT HOW LONG HAS THIS BEEN A CONCERN FOR YOU?

ARE YOU CURRENTLY ON ANY MEDICATIONS? (Please specify)

OVERALL HOW SERIOUS IS THIS PROBLEM FOR YOU?	NOT VERY SERIOUS ❑	SOMEWHAT SERIOUS ❑	VERY SERIOUS ❑

PLEASE STATE HOW THIS CONCERN HAS AFFECTED YOUR:	NOT AT ALL	SOMEWHAT	VERY MUCH
Marriage/ Partner	❑	❑	❑
Family	❑	❑	❑
Job/ School Performance	❑	❑	❑
Friendships	❑	❑	❑
Financial Situation	❑	❑	❑
Legal Situation	❑	❑	❑
Health	❑	❑	❑
Anxiety Level/ Nerves	❑	❑	❑
Mood	❑	❑	❑
Eating Habits	❑	❑	❑
Sleeping Habits	❑	❑	❑
Ability to Concentrate	❑	❑	❑
Child Rearing	❑	❑	❑
Ability to Control Your Temper	❑	❑	❑
Spirituality	❑	❑	❑