**Please complete this form before the first appointment with a counselor.**

**Client Demographics Date**

|  |  |
| --- | --- |
| Name:  |  |

|  |
| --- |
| Address:  |

**Legal Sex Gender Identity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Male |  | Non-binary/third gender |  | Transgender  |
|  | Female |  | Prefer to self-describe: |  | Prefer not to say |

|  |
| --- |
| Highest Level of Education:  |

**Employee Name, if Different than Client**

|  |
| --- |
| First, Middle, Last: |
| Relationship to Member: |
| Employee Address if Different than Client: |

**Contact Preferred Method of Contact**

|  |  |
| --- | --- |
| Phone Number: | Cell Phone, Text, E-Mail: |

**Contact In Case of Emergency**

|  |  |  |
| --- | --- | --- |
| Name:  | Relationship: | Phone #:  |

**Employment Information**

|  |  |  |
| --- | --- | --- |
| Employer:  | Position:  | Years of Service:  |

**Insurance Information (Only Used to Assist with Referrals)**

|  |  |
| --- | --- |
| Insurance Company: | Policy #: |
| Phone: | Group #: |

**Current Medical/Psychiatric Information - Check Boxes to Allow Permission to Contact**

**As Appropriate Sign Release of Information (ROI) Form(s) with Counselor**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Primary Care Physician:  | Phone #:  | Service Date: |
|  | Psychiatrist or Nurse Practicioner: | Phone #: | Service Date: |
|  | Holistic Provider: | Phone #: | Service Date: |
|  | Counselor/Therapist: | Phone #: | Service Date: |
|  | Other: | Phone #: | Service Date: |

**Mental/Psychiatric Health and Physical Health Factors – Indicate Past and Current Medical Conditions**

|  |
| --- |
| Current (Allergies, Diagnoses, Need for Assistive Technology, Pregnancy and Prenatal Care, Nicotine/Alcohol/Drug Use, etc.): |
| Hospitalization(s):If Yes, please explain: |
| Current Medication(s): |
| Past (Diagnosis, Head Trauma, Surgeries, etc.): |
| Past Medication(s): |
| Complimentary Medicine (Yoga, Meditations, Chiropractic, Massage, etc.): |
| Current Alternative Medication(s) (Vitamins, Minerals, Herbs, etc.): |
| Family History (Diagnoses, etc.): |

**Intellectual/Developmental**

|  |
| --- |
| Current (Diagnoses, Concerns, etc.): |
| Family History (Symptoms, Diagnoses, Concerns, etc.): |

**Child/Adolescent Client Information Only**

|  |
| --- |
| Pre-Natal History (Details of Pregnancy, Labor, Delivery, Medical Conditions, Mother’s Use of Medications, etc.):  |
| Factors to Consider (Elopement, Truancy, Domestic Violence, Starting Fires, Abuse to Animals, Eating Issues, Behavioral Issues, etc.): |

**Safety**

|  |
| --- |
| Have you ever had thoughts of or made a suicidal gesture or attempt? |
| If yes, please explain: |
| Have you ever had thoughts of or made a homicidal gesture or attempt? |
| If yes, please explain: |
| ***If you have current thoughts of harming yourself or others, please call the 24-hour National Suicide Prevention Lifeline at 1-800-273-TALK, 911, or go to the nearest emergency room.*** |

**History of Trauma (Experienced)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Verbal Abuse  |  | Neglect |  | Physical Abuse |  | Sexual Abuse/Assault |

**History of Trauma (Witnessed)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Verbal Abuse  |  | Neglect |  | Physical Abuse |  | Sexual Abuse/Assault |

**Reason(s) for Accessing the Employee Assistance Program (EAP)**

|  |
| --- |
| What brings you to counseling at this time? |
| What changes would you like to see as a result of working with a counselor? |
| What personal strengths and resources do you have that will help in achieving your goal(s)? |
| Who is your primary support in achieving your goal(s)? |
| In the past, how have you managed life’s challenges and stressors? |
| What healthy steps do you take for self-care? |
| What other information would like to share with a counselor? |

**To measure the effectiveness of EAP services, we will contact you by phone or e-mail to complete:**

|  |  |
| --- | --- |
| A Work Outcome Suite (WOS) Survey – Pre and Post Treatment | A Satisfaction Survey |

**Client Signature Date**

|  |  |
| --- | --- |
|  |  |

**Providers, please upload Client Forms to EAP Expert PROVIDERFiles.**