

GHS EMPLOYEE ASSISTANCE PROGRAM – CLIENT INFORMATION FORM

Please fill out this form as completely as possible. All information is kept confidential and used only for evaluating our program.

Company providing EAP benefit: _____ Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Work phone: () _____ Home phone: () _____ Cell phone: () _____

- 1. **Level of education achieved**
 8 grades or under
 9th through 11th
 High school graduate
 Some college
 College graduate
 Advanced degree

- 2. **Identify Gender**
 Male Female Other

- 3. **Marital Status**
 Single
 Married
 Divorced
 Separated
 Widowed
 Living with someone

- 4. **Who is attending this session?**
 Employee only
 Employee & family member(s)
 Family member(s) only

- 5. **Who referred you to EAP?**
 Supervisor formal referral
 Supervisor recommended
 Medical Dept/Employee Health
 Self
 Other

- 6. **If you are a family member, are you employed or volunteer?**
 Yes No

If so, where _____

- 7. **If your employer has more than one location, at which location do you work?**

- 8. **Type of work you do**
 Clerical
 Educator
 General laborer
 Management
 Professional
 Sales
 Technician

Job Title: _____

- 9. **Employment Status**
 Full-time
 Part-time
 As needed/on call
 Temporary
 Other

- 10. **Which shift do you work?**
 Days
 Evenings
 Nights
 Rotating
 Other

- 11. **How long have you worked for this employer?**

- 12. **Have you used EAP previously?**
 Yes No

If you were seen under a different name, indicate name.

If EAP was through a different company, indicate company.

- 13. **In the last 6 months have you had any work performance problems?**
 Absent
 Tardy
 Safety violations
 Problems relating to others
 Quantity/quality of work decreased
 Worker's Compensation Case
 Alcohol/drugs suspected
 Theft
 Other
 No problems at work

- 14. **Has your employer taken any of the following actions with you?**
 Counseled you on work problems
 Given a verbal/written warning
 Suspended you
 Demoted you
 Terminated you
 Resignation
 No actions taken
 Other

- 15. **How many days have you been absent (not vacation days) in the last 12 months?**
 No days
 1 - 5 days
 6 - 10 days
 11 - 15 days
 16 or more days

- 16. **Have you have lost time at work due to illness/injury in the past 6 months?**
 Yes No

Explain: _____

- 17. **How did you find out about EAP?**
 Prior participation
 Newsletter article
 Posters
 Brochure
 Supervisor suggested
 Co-worker suggested
 Family member suggested
 In-service training/Orientation
 Other: _____

- 18. **Do you have health insurance coverage?**
 Yes No

Name of Company: _____

Name of Insured: _____

- 19. **Indicate Primary Concern with #1 and Secondary Concern with #2. Check any others that apply.**

- Alcohol use
- Drug use
- Gambling
- Domestic abuse
- Family member's alcohol use
- Family member's drug use
- Family problem
- Parenting
- Marital
- Relationship
- Depression/Anxiety
- Emotional difficulties
- Grief and loss
- Stress
- Work related
- Health problems
- Financial
- Sexuality/Sexual Orientation
- Suicide
- Self-harm
- Other _____

- 20. **May we send a follow-up questionnaire to your home?**
 Yes No

- 21. **Please list current medications:**

- 22. **Please list any previous physical and/or mental health issues:**

- 23. **Have you previously seen a counselor?**
 Yes No

If so, whom _____

- 24. **Are you currently seeing a counselor?**
 Yes No

If so, whom _____

- 25. **Indicate substances you have previously used with P; substances you are currently using with C.**

- Alcohol
- Marijuana/Synthetic Marijuana
- Cocaine/Crack
- Huffing/Inhalants
- Methamphetamine/Stimulants
- Heroin
- Tobacco/e-Cigarettes
- Medication of someone else
- Caffeine

GUNDERSEN HEALTH SYSTEM EMPLOYEE ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

Welcome to the Gundersen Health System Employee Assistance Program (EAP). Being able to share a problem can do much to lessen the stress you may be experiencing. We provide employees and their family members with free, confidential assessment, short-term counseling, and referral services. This service is intended to assist employees and family members who, voluntarily, seek assistance to resolve personal problems that may be affecting their health, well-being, and/or job performance. Your employment or job advancement will not be affected as a result of your participation in the EAP. The following will provide you with basic information regarding your EAP and inform you of your rights and responsibilities as a client.

QUALITY OF SERVICE: All EAP consultants possess an appropriate level of education, training and experience necessary to provide high quality EAP assessment and referral services to you. Please feel free to ask your consultant about his/her credentials. The EAP staff will take your needs into consideration and uphold your personal dignity as they work with you. Because we believe it is important for you to find the right match with your EAP consultant, please contact the EAP office should you wish an alternate consultant. In addition, should you be dissatisfied with the service(s) you have received, please contact the EAP office assistant for grievance procedure guidelines.

FEES: Sessions with a consultant are offered at no direct cost to you or your family members. If you choose to accept a referral to another individual or agency, any financial charges will be your responsibility. Many services are available on an ability-to-pay basis or may be covered by your health insurance. While the EAP consultant will offer some assistance, it is your responsibility to determine whether or not such services are covered under your insurance plan.

PRIVACY: Information concerning your use of the EAP will not be given to anyone outside the EAP without your permission unless required by law. Certain state laws require that the EAP staff assume the responsibility for reporting to appropriate parties in instances when a person is a danger to him or herself, to others, or when a child or vulnerable adult abuse/neglect is involved.

OFFICE HOURS: EAP is available Monday through Friday. During regular business hours, the EAP office assistant can assist you with the scheduling of an appointment or in leaving a message for your consultant. After hours, on weekends, or holidays, EAP clients can call the EAP office at 608-775-4780 or 800-327-9991 and talk directly with the EAP back-up consultants. Should you or a family member need to see a consultant in person, you will be assisted in making those arrangements.

SUMMARY: If you have questions or concerns about the above information, please ask your EAP consultant or contact the EAP office.

I have read this Statement of Understanding in its entirety and do understand its content.

Client or Legal Guardian Signature

Date