

**GUNDERSEN HEALTH SYSTEM EMPLOYEE ASSISTANCE PROGRAM
CHILD & ADOLESCENT 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: _____ Birth date: _____ Age: _____

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

Home phone: () _____ Name of Parent(s)/Guardian you live with: _____

1. Are you presently in School?

____ Yes ____ No

If yes, Grade _____

If Yes, Name of School _____

2. Identify Gender

____ Male ____ Female ____ Other

3. Who is attending this session?

____ Self
____ Self & Family Member(s)
____ Self & Other

Specify _____

4. Who referred you to EAP?

____ Self
____ Family member
____ Physician
____ Other

5. Who do you currently live with?

____ Mother & Father
____ Mother & Stepfather
____ Father & Stepmother
____ Mother
____ Father
____ Stepmother
____ Stepfather
____ Legal Guardian
____ Foster Parent
____ Other Relative

Specify _____

6. Are you employed or do you volunteer? ____ Yes ____ No

If yes, where? _____

Number of hours worked or volunteered in a week? _____

How long have you worked or volunteered for this place? _____

7. Have you used EAP previously?

____ Yes ____ No

8. Have you ever been to a counselor in the past?

____ Yes ____ No

If yes, explain: _____

9. Are you currently seeing a counselor?

____ Yes ____ No

10. What do you like to do for fun and/or relaxation?

11. In the last 6 months have you had any of these school performance problems?

____ Absent
____ Unexcused Absence
____ Tardy
____ Skipping Classes
____ Suspension
____ Expelled
____ Change in Grades
____ Detention
____ Problems with Friends
____ Bullying

12. Has your school taken any of the following actions in regard to you?

____ Counseled you on school problems
____ Given a verbal/written warning
____ Suspended you
____ No actions taken
____ Other

13. How many days have you been absent in the last school year?

____ No days
____ 1 - 5 days
____ 6 - 10 days
____ 11 - 15 days
____ 16 or more days

14. Have you lost time at work or school due to an injury or illness in the in the past 6 months?

____ Yes ____ No

If yes, what was the injury or illness? _____

15. Have you ever tried any of the following substances?

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

16. Indicate Primary Concern with #1 and Secondary Concern with #2. Check any others that apply.

____ Relationship problem(s)
____ Family problem(s)
____ Emotional difficulties
____ Depression
____ Drug use
____ Alcohol use
____ Family member's use of alcohol
____ Family member's use of drugs
____ Eating problems
____ Grief and loss
____ Health problems
____ School related
____ Legal problems
____ Sexuality
____ Stress
____ Other: _____

17. How would you rate your present health?

____ Excellent ____ Good
____ Fair ____ Poor

18. What health problems have you had in the past?

19. If you are currently on any medications, please list them below:

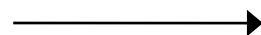
Medication _____
Reason _____

Medication _____
Reason _____

20. Do you have Health Insurance Coverage? ____ Yes ____ No

Name of Company _____
Name of Insured _____

OVER



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