Client Information Sheet

Note: The information on this form is presented only for use in Directions EAP. Copying or distribution of this information for any other purpose violates laws regarding confidentiality.

Client name: ______________________________

EAP Employer: ______________________________

Date of birth: ____/____/_____ **Age:**_________ **Male:**_____________ **Female:**___________

Home Address: ______________________ **City**_______________ **State**_____ **Zip** _________

Cell Phone: ______________________ **Work/Home Phone:**____________________

May we contact you: At: [ ] Cell [ ] Work/Home [ ] Please do not contact me.

May we leave a message: At: [ ] Cell [ ] Work/Home [ ] Please do not leave a message.

In case of emergency, please contact: ______________________**Phone Number:**________________

Demographic Information:
Living Status: [ ] Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed [ ] Other: ________

Relationship to Employee: [ ] Self [ ] Employee's Spouse/Significant Other [ ] Dependent Child
[ ] Other: ________________

Referred to EAP by: [ ] Self [ ] Supervisor Recommended [ ] Supervisor Mandated
[ ] Management [ ] Human Resources [ ] Family [ ] Other:____________

Learned about EAP from: [ ] Company Literature [ ] Family Member [ ] Human Resources
[ ] Co-Worker [ ] Management [ ] Other:________________

Requesting Assistance for: [ ] Addiction [ ] Emotional/Stress [ ] Financial/Legal [ ] Medical/Physical
[ ] Relationship(s) [ ] Work Issues [ ] Grief [ ] Other:________________

Health Insurance Provider: (if requested)

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____

Please briefly describe why you came to EAP and what you hope to accomplish: ______________________________

Has your work performance been impacted? If so how?______________________________

Has the reason you are seeking EAP help also resulted in workplace disciplinary action? [ ] No [ ] Yes,
Please describe:

Have you been a client of Directions EAP before? [ ] No [ ] Yes Approximately how long ago?______________

______________ ______________________________
Date **Signature**

CONSENT FOR TREATMENT & CONFIDENTIALITY
It is the policy of the Directions Employee Assistance Program (EAP) that information regarding clients is kept strictly confidential. As a general rule, we will not disclose to any person the fact that a client has requested or received services from the program, or any information that we learn about the client while providing services, unless disclosure is authorized by the client or required by law, subpoena, or court order.
You have the right to confidential services in that information regarding your visits to the EAP will not be disclosed to anyone without your specific written consent with the exception of certain imminent life-threatening circumstances, including danger to yourself or others, child abuse, and abuse of incompetent or disabled individuals.
If there are any other individuals such as supervisors at work or your family members who must access, or whom you would like to have access, to information about your status in the program, you should discuss this need with your EAP counselor. You may sign an authorization form to allow us to release this information.

PROTECTING YOUR CONFIDENTIALITY IS OF HIGHEST PRIORITY TO US. ANY CONCERNS YOU HAVE IN THAT REGARD SHOULD BE DISCUSSED WITH YOUR COUNSELOR OR THE PROGRAM DIRECTOR.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Directions, EAP LLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist.

By signing below, I acknowledge that I have read and understand this information.

______________ ______________________________
Date Signature

______________ ______________________________
Date Parent/Guardian Signature