**FOR FAX ONLY**

# OhioHealth Employee Assistance Program
# Client Information Form

Authorization Code: _____ Sex / Gender:

_____ Birthdate: __ __/__ __/__ __ __ __ Age: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Client is: _____ an employee of a company with the OhioHealth EAP.

_____ a spouse / partner of an employee with the OhioHealth EAP.

_____ a dependent child of an employee with the OhioHealth EAP.

**Department:** _____ **Job Title:** _____

## Emergency Contact:

Name_____ Relationship to Client: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance: _____

**I contacted the EAP primarily because:** _____

_____

On a severity scale of 1 (minimum severity) to 7 (maximum severity), how severe is the problem that brings you to the EAP? Please circle one of the following: **1 2 3 4 5 6 7**

## Check (✓) the problem areas that are relevant to your present life circumstance:

_____ Difficulties with spouse/partner
_____ Difficulties with a child/children
_____ Legal problems
_____ Medical/health problems
_____ Career issues
_____ Emotional problems
_____ Other _____

_____ Difficulties with alcohol / drugs
_____ Family member abusing alcohol / drugs
_____ Financial problems
_____ Difficulties with an aging parent
_____ School-related problems
_____ Behavioral Problems

**FOR FAX ONLY**

**Check (✓) the symptoms which describe how you are now feeling:**

| | | |
|---|---|---|
| _____ Physical complaints | _____ Memory changes | _____ Paranoia |
| _____ Sleep Disturbances | _____ Worry | _____ Decreased pleasure |
| _____ Weight changes | _____ Hopelessness | _____ Increased substance use |
| _____ Appetite changes | _____ Helplessness | _____ Risky behavior |
| _____ Fatigue | _____ Sadness | _____ Desire to isolate self |
| _____ Confusion | _____ Irritability | _____ Desire to hurt self |
| _____ Difficulty concentrating | _____ Anger | _____ Desire to hurt others |

**Name of Primary Care Doctor:** _____ **Doctor's Phone:** _____

**Current Medications:** _____

_____

**Check (✓) the work performance factors which are affected by your problem(s):**

_____ My problem is not affecting my work performance

| | | |
|---|---|---|
| _____ Increased absenteeism | _____ Accidents on the job | _____ Verbal warning from supervisor |
| _____ Increased tardiness | _____ No longer employed | _____ Written warning from supervisor |
| _____ Difficulty concentrating | _____ Unable to complete assigned tasks | _____ Interpersonal difficulties with: |
| _____ Suspended from work | _____ Lateness in completing assigned tasks | ___ *co-workers* ___ *supervisor* ___ *subordinates* |

**For OhioHealth associates, spouse / partner & dependents, please check one of the following:**

| | | |
|---|---|---|
| __Doctors Hospital | __Pickerington Medical Campus | __OhioHealth Employer Services |
| __Dublin Methodist Hospital | __Westerville Medical Campus | __OhioHealth Administration / Corporate |
| __Grady Memorial Hospital | __HomeCare / Hospice | __OhioHealth Star Corporation |
| __Grant Medical Center | __OhioHealth Neighborhood Care | __O'Bleness Hospital - Athens |
| __Hardin Memorial Hospital | __Riverside Methodist Hospital | __O'Bleness Nelsonville |
| __Mansfield Hospital | __Shelby Hospital | __Other _____ |
| __Marion General Hospital | __OhioHealth Physician Enterprise (OPG, MAP, HealthWorks, Mansfield/Shelby/O'Bleness Physicians) | |

**For non-OhioHealth Associates, please fill out the following:**

Company / organization name: _____

**FOR FAX ONLY**

# EAP Demographic Questions

*This data is collected so that we can best serve <u>all</u> associates.*
*EAP information is <u>not</u> stored in Electronic Medical Records (i.e., CareConnect) used elsewhere in OhioHealth.*

1. **<u>Race/Ethnicity</u>**

_____

2. **<u>Marital Status</u>**
   - ___ Divorced
   - ___ Domestic Partnership
   - ___ Married
   - ___ Single
   - ___ Widowed

3. **<u>Disability Status</u>**
   - ___ Disabled
   - ___ Not Disabled

4. **<u>Caregiving/Financial Responsibility</u>**
   - ___ Children
   - ___ Elders
   - ___ Both Children and elders
   - ___ Other
   - ___ No caregiving/financial responsibility

5. **<u>Military Service</u>**
   - ___ Active Military
   - ___ Reservist/National Guard
   - ___ Veteran
   - ___ None

6. **<u>Work Shift</u>**
   - ___ Day Shift
   - ___ Evening Shift
   - ___ Night Shift
   - ___ Other Shift
   - ___ Weekend only

7. **<u>Work Status</u>**
   - ___ Full Time
   - ___ Part Time
   - ___ Contingent
   - ___ Contract

8. **<u>Position</u>**
   - ___ Business Office/Finance/Registration Clerical
   - ___ 4 year degree required or more, other than RN or Physician
   - ___ Licensed or Technical Personnel (includes LPN)
   - ___ Maintenance
   - ___ Service and Other Clerical (includes PCA/PCT)
   - ___ Physician/Resident
   - ___ Registered Nurse
   - ___ Security/Safety Officers
   - ___ Manager
   - ___ Director
   - ___ Senior Leadership (Vice Presidents and above)
   - ___ Nurse Practitioner/Adv. Nurse Practitioner

   *Other
   _____