METHODIST HEALTHCARE
EMPLOYEE ASSISTANCE PROGRAM
REGISTRATION FORM

CASE NUMBER _____

COUNSELOR NUMBER _____

DATE _____

To be completed by the client (person receiving counseling)

Are You:

- ☐ Employee of contracted company
- ☐ Member of Household

Client Information:

Client First Name: _____ MI: _____ Last: _____

Client D/O/B: _____ Client Age: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Client Health Insurance: _____

Client Job Title: _____

Client Employer/School: _____

Client Primary Care Physician: _____

Work phone: (____) _____-_____ Ext _____ OK to call? Y/N Leave message? Y/N

Home phone: (____) _____-_____ OK to call? Y/N Leave message? Y/N

Cell phone: (____) _____-_____ OK to call? Y/N Leave message? Y/N

Employee Information:

Employee First Name: _____ MI_____ Last_____

Where does employee work: _____

Client Background Information

(Please Check Appropriate Answer)

EDUCATION

____8 grades or under
____9th through 11th
____H.S. Graduate
____Some College
____College Graduate
____Advanced Degree

ETHNIC BACKGROUND

____American Indian or
Alaskan Native
____Asian
____Black or African American
____Hispanic/Latino
____Native Hawaiian or
Pacific Islander
____Two or More Races
____White

GENDER

____Male ____Female

MARITAL STATUS

____Single
____Married # of Years _____
____Divorced
____Separated
____Widowed
____Living w/someone

Ages of Children/Step Children
_____

REFERRAL SOURCE

____ Supervisor Formal
____ Supervisor Recommendation
____ Medical Doctor or Employee Health
____ Human Resources
____ Self
____ Parent/Guardian
____ Other

WORK STATUS

____Full Time
____Part Time
____As Needed
____Temporary
____Other

SHIFT

____Days
____Evenings
____Nights
____Rotating
____Other

YEARS EMPLOYED IN CURRENT JOB

____Under 1 Year
____1 - 3 Years
____4 - 6 Years
____7 - 9 Years
____10 - 15 Years
____16 or More Years
____N/A Family Member
____Data Not Available

BEEN TO EAP BEFORE

____No
____Yes
If so when _____

AWARE OF EAP FROM:

____ Prior Participation
____ Newsletter
____ Posters
____ Brochures
____ Supervisor Suggested
____ Co-Worker Suggested
____ Family Suggested
____ In Service Training/ Orientation
____Other

Please indicate the primary problem that has led you to seek help:

- ☐ **Abuse/Addiction of Client**
- ☐ **Abuse/Addiction of Family Member**
- ☐ **Family Conflict**
- ☐ **Marital/Relationship**
- ☐ **Emotional Problems**
- ☐ **Trauma and Abuse**
- ☐ **Other_____**
- ☐ **Eating Disorder**
- ☐ **Work Related**
- ☐ **Medical Condition**
- ☐ **Financial**
- ☐ **Stress**
- ☐ **Legal**
- ☐ **Work/Life Balance**

Please answer the following:

YES NO Do you have any medical problems? If yes, please list.

_____

_____

YES NO Are you currently taking any medications? If yes, please list.
(Please include dose(s) if known)

_____

_____

YES NO Have you ever been prescribed mood altering/psychiatric medication? If yes, please list.

_____

_____

YES NO Have you had prior counseling? If yes, please list type and date.

_____

_____

YES NO Do you have significant problems with sleeping?

YES NO Have you had significant weight gain or loss?

YES NO Have you binged on food and/or intentionally vomited after eating?

YES NO Have you or anyone else had concerns over **YOUR** alcohol/drug use?

YES NO Have you or anyone else had concerns over **YOUR** gambling?

YES NO Have you ever thought about hurting yourself?

YES NO Have you ever thought about or attempted suicide?

YES NO Have you ever attempted to harm someone else?

Is there anything else your counselor needs to know in order to best help you?