PARKVIEW
EMPLOYEE ASSISTANCE PROGRAM

CLIENT INFORMATION FORM

To be completed by client *(or parent/guardian if client is a minor).*

Client's Name: _____ **Date of Birth:** _____

Address: _____ **City** _____ **State:** ____ **ZIP:** _____

Do we have your permission for the EAP counselor or secretary to contact you *(parent/guardian if minor):*

by phone? ❑ Yes ❑ No Phone Number: _____
Leave message on voicemail? ❑ Yes ❑ No
Leave message with person answering phone? ❑ Yes ❑ No

by email? ❑ Yes* ❑ No _____
*Email address:

Gender: ❑ Male ❑ Female ❑ _____

Marital Status: ❑ Married ❑ Separated ❑ Widow or Widowed
❑ Single ❑ Divorced ❑ Other

Ethnic Background: *(optional)* ❑ Caucasian ❑ African American ❑ Hispanic/Latino ❑ Asian
❑ Multiracial ❑ Native American ❑ Other Ethnic Origin

Childhood: **Where did you grow up?** _____ **Adopted?** ❑ Yes ❑ No

Relationship to Employee: ❑ Employee ❑ Spouse ❑ Child
❑ Dependent ❑ Partner ❑ Other Relationship

Primary Care Doctor: _____ **Insurance:** _____
(To assist with referrals if needed)

How did you hear about EAP? ❑ Company Literature ❑ Human Resources ❑ Nurse/Medical
❑ Management ❑ Other Employee ❑ Seminar
❑ Supervisor ❑ Union ❑ Other:

Referred by: ❑ Self-referral ❑ Human Resources ❑ School ❑ Coworker
❑ Supervisor ❑ Management ❑ Workman's Comp ❑ Union
❑ Family Member ❑ Nurse/Medical ❑ Other: _____

Has your employer mandated you to come to EAP? ❑ Yes ❑ No

Employee Information

Employee's Name: _____ **Date of Birth:** _____

Company: _____ **Location:** _____ **Division/Dept:** _____

Labor Grade: ❑ Management ❑ Non-Management

Job Shift: ❑ Day ❑ Evening ❑ Night ❑ Rotating ❑ Other Job Shift

Employee Category: ❑ Full Time ❑ Part Time ❑ Retiree ❑ Other

Length of Service (yrs): ❑ 1 or less ❑ 2 to 5 ❑ 6 to 10 ❑ 11 to 15 ❑ 16 to 24 ❑ 25+