

# EAP DATA FORM

**ID #** \_\_\_\_\_ (for office use only)

## DEMOGRAPHIC DATA – GENERAL

Employee Name:		
Employee Date of Birth:	Employer:	
Employee Soc. Sec. #:	<b>Specific Property (if casino)</b>	
Home Address:	Patient's Name:	
City, State, Zip:	Patient's Relationship to Employee:	
Home Phone: <span style="float: right;">OK to call [ ] Yes [ ] No</span>	Patient's DOB:	
Work Phone: <span style="float: right;">OK to call [ ] Yes [ ] No</span>	Patient's Soc. Sec. #:	
_____ _ Name of EAP Counselor	_____ _ Area Code & Phone Number	_____ _ City, State, Zip Code

## CLIENT DATA

Sex	Age	Marital Status	Type of Referral	Education Level
1. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female	1. <input type="checkbox"/> Under 25 2. <input type="checkbox"/> 25 - 34 3. <input type="checkbox"/> 35 - 44 4. <input type="checkbox"/> 45 - 54 5. <input type="checkbox"/> 55+	1. <input type="checkbox"/> Married 2. <input type="checkbox"/> Never Married 3. <input type="checkbox"/> Separated 4. <input type="checkbox"/> Divorced 5. <input type="checkbox"/> Widowed 6. <input type="checkbox"/> Cohabiting	1. <input type="checkbox"/> Self Referral 2. <input type="checkbox"/> Manager/Supervisor Referral 3. <input type="checkbox"/> Medical Referral 4. <input type="checkbox"/> Human Resources/Personnel Referral 5. <input type="checkbox"/> Other employee/coworker <input type="checkbox"/> Family member <input type="checkbox"/> Other -	1. <input type="checkbox"/> Some High School 2. <input type="checkbox"/> High School Diploma 3. <input type="checkbox"/> Some College 4. <input type="checkbox"/> College Degree 5. <input type="checkbox"/> Graduate School Degree 6. <input type="checkbox"/> Grade School (K-8)

Ethnic Background	Learned About EAP Through:
1. <input type="checkbox"/> African American 2. <input type="checkbox"/> Native American 3. <input type="checkbox"/> Asian/Pacific Islander 4. <input type="checkbox"/> Hispanic 5. <input type="checkbox"/> Caucasian 6. <input type="checkbox"/> Other: _____	1. <input type="checkbox"/> Home Mailing 2. <input type="checkbox"/> Literature/Poster 3. <input type="checkbox"/> Training Session 4. <input type="checkbox"/> Family Member 5. <input type="checkbox"/> Other Employee/Coworker 6. <input type="checkbox"/> Personnel 7. <input type="checkbox"/> Supervisor 8. <input type="checkbox"/> Medical 9. <input type="checkbox"/> Other _____

## IF CLIENT IS EMPLOYEE:

Length of Employment	Occupational Group	Shift	Performance Problems
1. <input type="checkbox"/> Less than 1 year 2. <input type="checkbox"/> 1 - 4 years 3. <input type="checkbox"/> 5 - 14 years 4. <input type="checkbox"/> 15 - 24 years 5. <input type="checkbox"/> 25+ years	1. <input type="checkbox"/> Admin/Mgmt 2. <input type="checkbox"/> Professional/Technical 3. <input type="checkbox"/> Sales/Marketing 4. <input type="checkbox"/> Clerical 5. <input type="checkbox"/> Operations/Maintenance 6. <input type="checkbox"/> Labor/Manufacturer 7. <input type="checkbox"/> Other: _____	1. <input type="checkbox"/> 1 <sup>st</sup> 2. <input type="checkbox"/> 2 <sup>nd</sup> 3. <input type="checkbox"/> 3 <sup>rd</sup> 4. <input type="checkbox"/> Rotating	1. <input type="checkbox"/> Absenteeism/Tardiness 2. <input type="checkbox"/> Misconduct/Disruptive behavior 3. <input type="checkbox"/> Safety Violation/Accident 4. <input type="checkbox"/> Intoxication 5. <input type="checkbox"/> Quality/Quantity of Work 6. <input type="checkbox"/> Problem with Supervisor 7. <input type="checkbox"/> Problem with Coworker 7. <input type="checkbox"/> Other Infraction of Company Policy 8. <input type="checkbox"/> None/Not Applicable

**PLEASE COMPLETE REVERSE SIDE**

Patient Name \_\_\_\_\_ Employer Group \_\_\_\_\_

**CLIENT CLINICAL DATA**

PRESENTING PROBLEM (CHECK ALL THAT APPLY)	ASSESSED PROBLEM (CHECK ALL THAT APPLY)	REFERRAL RECOMMENDATIONS: (CHECK ALL THAT APPLY)
1. <input type="checkbox"/> Alcohol 2. <input type="checkbox"/> Prescription Drugs 3. <input type="checkbox"/> Other Drugs _____ 4. <input type="checkbox"/> Gambling 5. <input type="checkbox"/> Emotional 6. <input type="checkbox"/> Marital/Significant Other 7. <input type="checkbox"/> Family/Children 8. <input type="checkbox"/> Physical Health 9. <input type="checkbox"/> Other Person-Alcohol/Drug 10. <input type="checkbox"/> Other Person-Emotional 11. <input type="checkbox"/> Legal 12. <input type="checkbox"/> Financial 13. <input type="checkbox"/> Career 14. <input type="checkbox"/> Work Induced Stress 15. <input type="checkbox"/> Social Services	1. <input type="checkbox"/> Alcohol 2. <input type="checkbox"/> Prescription Drugs 3. <input type="checkbox"/> Other Drugs _____ 4. <input type="checkbox"/> Gambling 5. <input type="checkbox"/> Emotional 6. <input type="checkbox"/> Marital/Significant Other 7. <input type="checkbox"/> Family/Children 8. <input type="checkbox"/> Physical Health 9. <input type="checkbox"/> Other Person-Alcohol/Drug 10. <input type="checkbox"/> Other Person-Emotional 11. <input type="checkbox"/> Legal 12. <input type="checkbox"/> Financial 13. <input type="checkbox"/> Career 14. <input type="checkbox"/> Work Induced Stress 15. <input type="checkbox"/> Social Services	1. <input type="checkbox"/> Inpatient Mental Health 2. <input type="checkbox"/> Inpatient Alcohol/Drugs 3. <input type="checkbox"/> Inpatient Other _____ 4. <input type="checkbox"/> Outpatient Counseling - Private 5. <input type="checkbox"/> Outpatient Counseling - Public 6. <input type="checkbox"/> Outpatient Alcohol/Drugs 7. <input type="checkbox"/> Outpatient Other _____ 8. <input type="checkbox"/> Self-help - AA/NA 9. <input type="checkbox"/> Self-help - GA 10. <input type="checkbox"/> Self-help - Family Groups 11. <input type="checkbox"/> Self-help - Other _____ 12. <input type="checkbox"/> Legal 13. <input type="checkbox"/> Financial 14. <input type="checkbox"/> Social Services 15. <input type="checkbox"/> Other _____ 16. <input type="checkbox"/> Client Still in EAP 17. <input type="checkbox"/> No Referral Necessary

**SESSION DATA**

Date(s) of Sessions:

Date	No. of People Attending	Date	No. of People Attending
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Total Number of Sessions: \_\_\_\_\_

**FINAL CASE DISPOSITION**

1. <input type="checkbox"/> No Referral Necessary, EAP sufficient	4. <input type="checkbox"/> Client Dropped Out
2. <input type="checkbox"/> Referral Recommended and Accepted	5. <input type="checkbox"/> Client Still in EAP
3. <input type="checkbox"/> Referral Recommended and Refused	6. <input type="checkbox"/> Other _____

**DATE CASE CLOSED** \_\_\_\_\_