TriCity Family Services

CLIENT/FAMILY HISTORY
Employee Assistance Program

Name:_____ Date:_____

Home Address:_____
Street City State Zip

Home Phone:_____ Work Phone: _____ S.S. #:_____

Age:_____ Date of Birth:_____ Your Employer:_____

Division/Location:_____ Employee/Member Name:_____

Department _____ Job Title:_____ S.S. #:_____

May we contact you by phone: At Home ☐ **Yes** ☐ **No** At Work ☐ **Yes** ☐ **No** By Mail? ☐ **Yes** ☐ **No**

May we call to remind you of upcoming appointments? ☐ **Yes** ☐ **No** At what number? (___)_____

RACE
- ☐ Caucasian
- ☐ African American or Black
- ☐ Hispanic/Latino
- ☐ American Indian/Native Alaskan
- ☐ Asian/Pacific Islander
- ☐ Other Racial/Ethnic
- ☐ Racial/Ethnic Group not known

EDUCATION
- ☐ 8 Grades or Less
- ☐ 11 Grades or Less
- ☐ High School Diploma
- ☐ Some College
- ☐ College Grad
- ☐ Advanced Degree

SEX
- ☐ Male
- ☐ Female

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Other

REFERRAL SOURCE
- ☐ Supervisor (mandated work referral)
- ☐ Supervisor (not mandated work referral)
- ☐ Human Resources
- ☐ Self
- ☐ Other

EMPLOYMENT STATUS
- ☐ Full Time
- ☐ Part Time
- ☐ As needed
- ☐ Temporary
- ☐ Other
- ☐ N/A Family Member

OCCUPATIONAL STATUS
- ☐ Salary
- ☐ Hourly
- ☐ N/A Family Member

SHIFT
- ☐ Days
- ☐ Evenings
- ☐ Night
- ☐ Rotating
- ☐ Other
- ☐ N/A Family Member

LENGTH OF SERVICE
- ☐ Under 1 Year
- ☐ 1 - 3 Years
- ☐ 4 - 6 Years
- ☐ 7 - 9 Years
- ☐ 10 - 15 Years
- ☐ 16 or More Years
- ☐ N/A Family Member

INTRODUCED TO EAP BY:
- ☐ Family Member
- ☐ Employee Orientation
- ☐ Co-Worker
- ☐ Brochure
- ☐ Newsletter
- ☐ Supervisor
- ☐ Poster
- ☐ Employee Seminar
- ☐ Other

BEEN TO EAP BEFORE
- ☐ No
- ☐ Once
- ☐ Twice
- ☐ Three Times
- ☐ Four Times
- ☐ Five or More Times

What concern(s) brings you to the Employee Assistance Program (EAP)?

_____

_____

_____

What changes do you want to see as a result of coming to the EAP?

_____

_____

_____

Client's Medical History

Currently under a doctor's care: □ **Yes** □ **No** Doctor (s) involved in your care:_____

Health problems (include allergies):_____

Medication currently used: □ None

Medication	Dosage	Doctor Prescribing	Why Prescribed

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: □ None

Date(s)	Reason (s)	Hospital

Previous Counseling, EAP or Chemical Dependency Services: □ None

Facility/Counselor Name	Date (s)	Reason (s)	Helpful?

Household Members

Name	Birth Date	Relationship to You	Marital Status *(Note Choices below)	Race/Ethnicity *(Note Choices below)	Education Level	Living at Home	Social Security #

* **Marital Status options**: Married, Single, Cohabiting, Separated, Divorced, Widowed

* **Race/ Ethnicity options:** White, African American, Hispanic, Native American, Asian, Other

Family Medical History

Are any of the household members listed above currently under a doctor's care? □ **Yes** □ **No**

If you answered *"Yes"* to the above question, please give name(s) of household members and the medical condition for which they are being treated:

Name	Condition

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: ☐ None

Date(s)	Reason (s)	Hospital

Previous Counseling, EAP or Chemical Dependency Services: ☐ None

Facility/Counselor Name	Date (s)	Reason (s)	Helpful?

Do you have veteran benefits? ☐ Yes ☐ No

Should you need services beyond your EAP benefit, we may need to contact your insurance provider for a referral or to verify your benefits and bill your insurance company if you continue services at our agency. Please provide us with your insurance information and your permission to do so.

A. Check a box and sign below, or skip to Section B.

☐ I do not have insurance.

☐ I have insurance, but I do not wish to use it.

SIGNED _____ DATE _____

B. I authorize TriCity Family Services to release the information below in order to coordinate a referral or file a claim on my behalf.

Employee_____

Social Security # and/or ID#_____ Group #_____

Name of Insurance Company: _____

Insurance Company Phone# _____

Insurance Company Address:_____
(street) (city) (state) (zip)

The insured or authorized person's signature is required if you are using your insurance benefits for:

1. The release of any medical or other information necessary to coordinate a referral or process a claim.
2. The payment of medical benefits to TriCity Family Services who accepts assignment for its services.

SIGNED _____ DATE _____

TriCity Family Services

Symptom Checklist

Please complete for each person attending the first appointment

Client's Name: _____ Date: _____

Person Completing Form: _____

Please check how often these symptoms occurred *in the last 6 months.* If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months.*

SYMPTOM	Never or rarely	A few times a month	Nearly every day	SYMPTOM	Never or rarely	A few times a month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach Problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			