CHART NUMBER:_____(office use only)

COUNSELOR: _____(office use only)

ATRIUM HEALTH
CLIENT INFORMATION RECORD

YOUR NAME: LAST _____ FIRST _____ MIDDLE INITIAL

SS #: _____-_____-_____ **DATE:** _____

COMPANY NAME: _____

ARE YOU THE:

1. ___ EMPLOYEE (OF ATRIUM HEALTH or EAP CONTRACT COMPANY)
2. ___ EMPLOYEE'S SPOUSE
3. ___ EMPLOYEE'S CHILD/DEPENDENT
4. ___ EMPLOYEE'S SIGNIFICANT OTHER
5. ___ OTHER RELATIVE, PLEASE SPECIFY:

HOME ADDRESS: ***May we send a letter to your home?*** _____ ***YES*** _____ ***NO***

Street _____

P.O. Box _____

City _____ State _____ ZIP _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____ -_____ Ext. _____

Cell Phone: (_____) _____-_____

CAN WE LEAVE A DETAILED MESSAGE ON VOICEMAIL? IF SO, WHICH NUMBER? _____

DATE OF BIRTH: _____/_____/_____ **GENDER: M ____ F _____ OTHER ____**

MARITAL STATUS:

1. _____MARRIED
2. _____SINGLE
3. _____DIVORCED
4. _____SEPARATED
5. _____ WIDOWED
6. _____LIVE WITH PARTNER

REFERRED TO THIS OFFICE BY: (PLEASE CHECK ONE)

_____Self _____Manager Suggested ____Nurse/Medical _____Positive Drug Screen

_____ Supervisor Mandated (Supervisor's Name_____ Phone_____)

IS IT APPROPRIATE TO CONTACT YOU AT WORK? Y N (circle one)

HOW DID YOU HEAR ABOUT OUR PROGRAM? (CHOOSE ONE)

1. ___ READ A BROCHURE/SAW A POSTER
2. ___ LISTENED TO A PRESENTATION
3. ___ A FAMILY MEMBER TOLD ME
4. ___ A FRIEND/CO-WORKER TOLD ME
5. ___ MY DOCTOR/THERAPIST SUGGESTED I COME
6. ___ HUMAN RESOURCES/EMPLOYEE HEALTH RECOMMENDED I COME
7. ___ COMPANY INTRANET
8. ___ DISPLAY BOOTH
9. ___ WALLET CARDS
10. ___ MY INSURANCE COMPANY
11. ___ MANAGER/SUPERVISOR
12. ___ HAVE BEEN HERE BEFORE

RACE:

1. ____ CAUCASIAN
2. ____ AFRICAN AMERICAN
3. ____ ASIAN/PACIFIC ISLANDER
4. ____ HISPANIC
5. ____ NATIVE AMERICAN
6. ____ OTHER, PLEASE SPECIFY

EDUCATION/MILITARY EXPERIENCE: (CHOOSE ONE-HIGHEST ATTAINED)

1. ___ 1-12 YEARS (no diploma)
2. ___ HIGH SCHOOL GRADUATE OR GED
3. ___ 1-4 YEARS COLLEGE (no degree)
4. ___ RN (w/out Bachelor)
5. IF COLLEGE GRADUATE, CHECK THE HIGHEST DEGREE ATTAINED:
   ____ASSOCIATE ___ MASTER ___ MD/DO
   ____BACHELOR ___ LAW ___ PHD/PHARMD/OTHER DOCTORATE
6. HAVE YOU EVER SERVED IN THE MILITARY ___YES ___NO
   IF YES, WHAT BRANCH _____ YEARS OF SERVICE _____

IF YOU ARE AN EMPLOYEE, PLEASE COMPLETE THE FOLLOWING:
(IF YOU ARE A FAMILY MEMBER, PLEASE SKIP TO FAMILY MEMBER INFORMATION BELOW)

DATE OF HIRE: _____ **SHIFT: _____**

POSITION:_____ **DEPARTMENT:_____**

JOB CLASSIFICATION:

1. ___ MANAGEMENT/EXECUTIVE
2. ___ PROFESSIONAL/TECHNICAL
3. ___ NURSING
4. ___ OFFICE/ADMINISTRATIVE SUPPORT
5. ___ MANUFACTURING/OPERATIONS
6. ____ SALES/MARKETING
7. ____ STUDENT/INTERN/OTHER TRAINING ROLE
8. ____ MAINTENANCE/DIETARY/ENVIRONMENTAL SVCS.
9. ____ DRIVER

FAMILY MEMBER INFORMATION
ARE YOU EMPLOYED OR ATTEND SCHOOL?
IF YES, THEN WHERE?
COMPANY/SCHOOL: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: (_____) _____ - _____

WHAT BRINGS YOU HERE TODAY?

_____

_____

_____
_____

PLEASE LIST ANY CURRENT OR RECENT MAJOR STRESSORS:

Y	N		Y	N	
___	___	DEATH OF LOVED ONE	___	___	CHILD CARE PROBLEMS
___	___	JOB CHANGE	___	___	PROBLEM WITH PARENT(S)
___	___	LOSS OF SIGNIFICANT RELATIONSHIP	___	___	QUALITY OF LIFE
___	___	DIVORCE	___	___	LIFE CYCLE CHANGES
___	___	SEPARATION	___	___	ILLNESS OR INJURY TO SELF OR OTHER
___	___	FINANCIAL PROBLEMS			
___	___	CHANGE OF RESIDENCE	___	___	TRAVEL FOR BUSINESS OR PLEASURE
___	___	SCHOOL PROBLEMS	___	___	VICTIM OF A CRIME
___	___	PROBLEM WITH SPOUSE OR SIGNIFICANT OTHER	___	___	CAREER PROBLEMS
			___	___	ABUSED AS A CHILD
___	___	PROBLEM WITH CHILDREN OR NEW CHILD	___	___	JOB STRESS
___	___	OTHER, PLEASE DESCRIBE: _____			

_____

_____

PLEASE DESCRIBE ANY HEALTH CONDITIONS YOU MAY CURRENTLY HAVE OR HAVE BEEN TREATED FOR:

___	___	RESPIRATORY	___	___	EAR, NOSE, THROAT
___	___	CARDIOVASCULAR	___	___	AUTOIMMUNE DISORDER
___	___	STOMACH/GASTROINTESTINAL	___	___	DIABETES
___	___	MUSCULOSKELETAL	___	___	BLOOD DISORDERS
___	___	SKIN			

OTHER, PLEASE DESCRIBE: _____

_____

_____

ARE YOU TAKING ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS? IF SO, PLEASE LIST:

_____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR A MENTAL HEALTH DISORDER, SUCH AS DEPRESSION OR ANXIETY? IF SO PLEASE DESCRIBE YOUR SYMPTOMS AND TREATMENT, INCLUDING COUNSELING EXPERIENCE:

_____

_____

_____

HOW WOULD YOU DESCRIBE YOUR CURRENT LEVEL OF STRESS?

____ NONE ____ MILD ____ MODERATE _____ SEVERE

HOW WOULD YOU DESCRIBE YOUR CURRENT MOOD?

_____

_____

In the last seven days have you have any thoughts about killing yourself or anyone else?
_____Yes _____ No

DO YOU USE ILLIEGAL DRUGS OR PRESCRIPTION DRUGS OTHER THAN PRESCRIBED? ____ No ____Yes
If **"Yes"**, how often? _____
For how many years? _____

How often do you have a drink containing alcohol?
(0) Never [Skip to FAMILY HISTORY]
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

IS THERE A FAMILY HISTORY OF SUBSTANCE ABUSE OR MENTAL HEALTH PROBLEMS?

PSYCHIATRIC		ALCOHOL		OTHER DRUGS		
Y	N	Y	N	Y	N	
___	___	___	___	___	___	MOTHER
___	___	___	___	___	___	FATHER
___	___	___	___	___	___	SIBLING
___	___	___	___	___	___	AUNTS
___	___	___	___	___	___	UNCLES
___	___	___	___	___	___	OTHER: _____

Thank you for your complete and honest answers to these important questions. All of this information will be kept confidential by the EAP. By signing below, you certify that the information above is true to the best of your knowledge.

_____
Client Signature

Reviewed: _____

REVISED 02.07.2019