NOVANT HEALTH

Date: ______________________

Name: ______________________________________ Date of Birth: ______________

Address: ______________________________ City: __________ State: ______ Zip: ______

Work Phone: ( ) ______________ OK to call? ☐ Home Phone: ( ) ______________ OK to call? ☐

Mobile: ( ) ______________ OK to call? ☐

Facility: ______________________ Department: ______________ Position: ______________

Education		Ethnic Background		Gender
☐ 8th grade or less	☐ Some College	☐ American Indian	☐ White	☐ Male
☐ 9th-11th grade	☐ College Grad	☐ Black/African-Amer	☐ Hispanic/Latino	☐ Female
☐ H.S. Graduate	☐ Advanced Degree	☐ Alaskan Native	☐ Native Hawaiian	
		☐ Asian	☐ Two or more races	

Marital Status		Work Status		Length of Service		Shift	
☐ Single	☐ Divorced	☐ Full Time	☐ Part Time	☐ Under 1 Year	☐ 7-9 Years	☐ Days	
☐ Married	☐ Separated	☐ PRN	☐ Other	☐ 1-3 Years	☐ 10-15 Years	☐ Evenings	
☐ Widowed	☐ Other	☐ **Family Member**		☐ 4-6 Years	☐ 16 or more	☐ Nights	
				☐ **Family Member**		☐ Rotating	☐ **Family**

Referral Source		Previous EAP?		Aware of EAP?	
☐ Self	☐ Employee Health	☐ No	☐ Once	☐ Past Visit	☐ Brochure
☐ Supervisor Suggestion	☐ COMPASS	☐ Twice	☐ Three	☐ Supervisor	☐ Co-worker
☐ Supervisor Formal	☐ Other	☐ Four or More		☐ Family	☐ Training/Orientation
☐ Employee Relations				☐ Website	☐ Other

Performance Issues		Disciplinary Actions	
☐ None	☐ Problems with Co-workers	☐ No Action Taken	☐ Coaching/Counseling
☐ Absences	☐ Work Quality	☐ Oral/Written Warning	☐ Suspension
☐ Tardy	☐ Alcohol/Drugs	☐ Demotion	☐ Termination
☐ Safety	☐ Customer Service	☐ Resignation	☐ Appeal
☐ Other	☐ **Family Member**	☐ Other	☐ **Family Member**

Absences (Last 12 Months)				Injury (Last 12 Months)
☐ No Days	☐ 1-5	☐ 6-10	☐ 11-15	☐ No ☐ Yes ☐ **Family Member**
☐ 16+	☐ FMLA	☐ **Family Member**		

If Supervisor Referral, Name of Supervisor	Supervisor's Phone Number

Information you share will be held in the strictest of confidence as explained in "The Statement of Understanding"

What brings you to the Employee Assistance Program today? ______________________________

____

____

Please complete the back of this page

Who is your Primary Care Physician?____

Current medications and reason prescribed:______________________________________

____

____

____

Please indicate any significant changes over the last three years by checking the appropriate box:

☐ Deaths	☐ Relocation	☐ Promotion	☐ Injuries	☐ Surgery
☐ Job Loss	☐ Births	☐ Illnesses	☐ Marital Status	☐ Other

To assist the counselor please provide as much of the following information as possible:

Substance Use:

Relief drinking or drug use?	☐ yes	☐ no
Self/Other's concerned with your use?	☐ yes	☐ no
Work issues related to your use?	☐ yes	☐ no
Family history of substance abuse or treatment?	☐ yes	☐ no
Legal issues related to substance use?	☐ yes	☐ no

Violence/Depression Inventory:

Recent domestic violence?	☐ yes	☐ no
History of domestic violence?	☐ yes	☐ no
Any thoughts or plans of hurting someone else?	☐ yes	☐ no
Depression?	☐ yes	☐ no
Any thoughts or plans of hurting yourself?	☐ yes	☐ no

Please mark any that may be affecting you:

☐ Decreased Sleep	☐ Decreased Appetite
☐ Increased Sleep	☐ Increased Appetite
☐ Poor Concentration	☐ Hopelessness
☐ Fatigue	☐ Social Isolation
☐ Loss of Pleasure	☐ Helplessness
☐ Frequent Crying	☐ Financial Issues
☐ Spiritual Life	

Family History of:

Mental illness or emotional problems?	☐ yes	☐ no
Domestic violence?	☐ yes	☐ no

Legal History:

Have you ever been arrested?	☐ yes	☐ no
Have you ever been convicted of a crime?	☐ yes	☐ no

Quarterly we ask clients to complete a survey so we can monitor our work. May our administrative specialist email you a follow-up questionnaire? Yes ☐ No ☐ If "yes", the best email address:______________________________

Emergency Contact: ______________________________ Phone: ______________ Relationship: ____________