Form # 2 (To be completed by client or parent/guardian)

CONFIDENTIAL CLIENT INTAKE **Client #** _____

CARILION EMPLOYEE ASSISTANCE PROGRAM

Legal Last Name: _____ **Legal First Name**: _____
Name you preferred to be called: _____
Name to use when calling you: _____
If minor, legal parent/guardian: _____
Date of Birth: _____ **Social Security #** (if DOT): _____

Mailing Address: _____
City: _____ **State**: _____ **Zip Code**: _____
Physical Address (if different):_____

Phone Number: _____ **Alternate Phone Number**: _____
Is it okay to leave a message? ☐ Yes ☐ No
Email Address: _____
Is it okay to email you? ☐ Yes ☐ No
Would you like to receive reminders for your appointment? ☐ Yes ☐ No
If yes, how would you like to receive your reminder? ☐ Phone ☐ Email

Gender: _____
Relationship Status: ☐ Single ☐ Married ☐ Partnered
☐ Domestic Partner/Civil Union ☐ Separated from spouse/partner
☐ Divorced/Permanently separated ☐ Other _____

Company providing EAP benefit: _____ **Location**: _____
Relationship to Employee: _____

How did you learn about your EAP benefit:
☐ Co-worker ☐ Family member ☐ Printed material
☐ Human Resources ☐ Orientation/training ☐ EAP Website
☐ Referred by supervisor ☐ Previous experience with EAP

If you are the employee, please answer the following:

Work Shift	**Employment Status**
☐ Day	☐ Full-time
☐ Evening	☐ Part-time
☐ Night	☐ Flex-time

Years employed with your company: _____
Job title: _____

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CARILION EMPLOYEE ASSISTANCE PROGRAM

SYMPTOMS CHECKLIST

The purpose of this checklist is to assist you and your counselor in identifying life areas that may be a concern for you or your family members. Your overall involvement with the Employee Assistance Program and your answers to these questions are confidential. Please check (✓) the symptoms you have been experiencing in the last 3 months:

☐ Body aches _____
☐ Sweating _____
☐ Tingling sensation or ☐ Numbness _____
☐ Chills
☐ Restlessness
☐ Oversleeping
☐ Frequent crying
☐ Racing thoughts
☐ Choking sensation
☐ Fear of going crazy
☐ Feeling worthless
☐ Pressure to keep talking
☐ Lack/loss of interest in things
☐ Unstrained buying sprees
☐ Excessive feeling of guilt
☐ Nausea or ☐ Vomiting
☐ Easily fatigues or ☐ Low energy
☐ Feeling lightheaded or ☐ Dizzy
☐ Weight loss or ☐ Weight gain
☐ Agitation/slowed bodily movements
☐ Frequent thoughts of death or suicide
☐ Other _____

☐ Muscle tension _____
☐ Trembling/shaking _____
☐ Chest pain
☐ Irritability
☐ Pounding heart
☐ Easily distracted
☐ Low self-esteem
☐ Shortness of breath
☐ Difficulty concentrating
☐ Hopeless
☐ Feeling sad/down in the dumps
☐ Feeling like living in a dream
☐ Decreased need for sleep
☐ Trouble making decisions
☐ Decreased or ☐ Increased sexual drive
☐ Difficulty falling or ☐ Staying asleep
☐ Decrease or ☐ Increase in appetite
☐ Seeing or ☐ Hearing things that are not real

Carilion EAP follows the RESPECTFUL Model. If you would like your counselor to pay special attention to any of the following, please circle the letter:

R – Religious and Spiritual Orientation
E – Ethnic / Cultural / Racial backgrounds
S – Sexual Identity / Orientation
P – Psychological Maturity
E – Economic Class Standing
C – Current Chronological Challenges
T – Trauma History and Threats to Personal Wellness
F – Family History and Influence
U – Unique Physical Characteristics
L – Location / Language

Form # 3 To Be Completed By Client And Signed By The Counselor

STATEMENT OF UNDERSTANDING

CARILION EMPLOYEE ASSISTANCE PROGRAM

Welcome! We are pleased you have decided to visit us. Before your session begins, we request that you review the following information, and if you have any questions, please ask your counselor.

Sharing personal problems can be difficult and we make every effort to maintain your confidentiality. Unless you give us written permission to do so, we do not share information you discuss *except* for reasons cited below:

1. If the EAP counselor believes that you or another person is at risk of harm or in cases where there is evidence of child abuse or elder abuse, we are required by law to inform an appropriate agency or individual. EAP must also comply with a court order and release the requested information.

2. If your supervisor makes a formal or a mandatory referral to EAP because of work performance problems or safety concerns, your counselor will advise the company representative whether the appointments are kept, whether issues are identified, and whether recommendations are being followed. No personal information is shared.

Your sessions with the EAP counselor are offered at no direct cost to you or to your family. **No-show appointments shall be counted as a used session against the bank of available sessions when the employee or family member does not notify the EAP office 24 hours prior to the appointment time of their intent to cancel.** If you need longer-term counseling or specialized services, the EAP will assist you in locating a resource in the community. Your health insurance plan may defray some or all of the cost of service; however, it is your responsibility to verify that insurance will cover the cost of therapy or other treatment and to pay any charges not covered.

Participation in the EAP is voluntary and employment or advancement with your company is not affected by your decision to use (or not to use) the services of Carilion EAP or its contracted affiliates.

BY MY SIGNATURE BELOW:
I understand that my counselor will provide an assessment, diagnosis and recommendations for ongoing treatment if he/she believes I would benefit from further assistance. I also understand that in seeking treatment with the Employee Assistance Program, I am involved in decisions on my continued course of treatment. I consent to use or disclosure of my protected health information to carry out treatment or health care operations by Carilion Employee Assistance Program or by its contracted subcontractors. I acknowledge that care will be provided in accordance with all federal and state confidentiality regulations including HIPPA and HITECH that assures notification of any unauthorized disclosures.

I acknowledge that I have read the above *Statement of Understanding* and therefore give consent for counseling. If applicable: My child, _____(name) is under the age of 18 and I am the primary custodial parent or have joint custody, and hereby give consent for treatment.

_____

Signature of Client or Parent or Guardian (if client is under 18 years old) Date

_____

Signature of EAP Counselor Date

Rev 9/14