CONCERN: EAP Client Information Form (Page 1 of 2)

Client Name _____ Counselor Name _____

To be completed about the Client (the adult or child receiving services)

Client Name _____ Date of Birth _____
FIRST M.I. LAST

Address _____ Check if client under 18 yrs. ☐

City _____ State _____ Zip _____ Gender: ○ Male ○ Female

Please provide a phone number where you may be reached and messages left: _____ ○ Home ○ Work ○ Mobile

E-mail _____ Health Insurance Carrier _____

Marital Status: ○ Single ○ Domestic Partners ○ Married ○ Separated ○ Divorced ○ Widowed

Spouse/Partner Name _____ Date of Birth _____

Names of other family members living with you	**Relationship *(Child, Parent, etc)***	**Age**	**Gender**

Preferred Language & Ethnicity

Your preferences will be kept strictly confidential. Asking you also allows us to provide you with the highest quality of service. Federal and State regulations require we ask this information to insure that we are meeting the needs of all the populations that we serve.

In what language do you feel most comfortable speaking? *please choose one* ○ English ○ Other: _____

In what language would you prefer to receive written materials? *please choose one* ○ English ○ Other: _____

How would you best describe your ethnic group? Check one or more of the following that apply:

☐ African American or Black
☐ American Indian or Alaska native
☐ Asian
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Multiracial
☐ Not sure (unknown ethnic/racial origin)
☐ I prefer not to state

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Summary of Medical History

Please complete if you are the client (for dependents see below)

◯ Yes ◯ No Have you been in counseling before? History: _____

_____

◯ Yes ◯ No Do you have current significant medical problems? Please describe: _____

_____

◯ Yes ◯ No Are you currently taking any medication for mental health treatment? Please list: _____

◯ Yes ◯ No Have you ever had thoughts of, expressed desire to, or attempted to self-harm (i.e. suicidal thoughts, cutting)?

☐ Currently ☐ In the Past Please Explain: _____

How often do you use alcohol or use recreational drugs? ◯ Not at all ◯ Once/month or less ◯ 2 or more times/week ◯ Daily

Do you think that you use alcohol to excess? ◯ Yes ◯ No ◯ Unsure

Do you think that you use drugs to excess? ◯ Yes ◯ No ◯ Unsure

Please complete if the client is your dependent

◯ Yes ◯ No Has your child been in counseling before? History: _____

_____

◯ Yes ◯ No Does your child have current significant medical problems? Please describe: _____

_____

◯ Yes ◯ No Does your child currently take any medication for mental health treatment? Please list: _____

◯ Yes ◯ No Has your child ever expressed the desire to hurt themselves, or attempted to self-harm? (i.e. suicidal thoughts, cutting)?

☐ Currently ☐ In the Past Please Explain: _____

Is there anything else your counselor should know?

Thank you for taking the time to complete this form.
This information will assist your counselor in providing services to you and your family.
All information is kept confidential and may not be released without your consent. Please ask your counselor if you have any questions.