



Client Information Form

Client Name: _____

Case # _____ [Magellan will supply the number]

First Appointment Date: _____

Address:		City:
State:	ZIP:	Do we have permission to contact you at the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
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Work Telephone Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Telephone Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Employer or Organization through which you are accessing EAP:				
Employee's Social Security Number (required):		Employee's Job Title:		Length of Service:

Your Status:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee Spouse	<input type="checkbox"/> Employee Child	<input type="checkbox"/> Other
	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree Spouse	<input type="checkbox"/> Retiree Child	

Do you have health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(if Yes) Name of organization(s) through which you are covered:
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How did you access the EAP?	<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Family Initiated	<input type="checkbox"/> Medical Department Referral/Human Resources	<input type="checkbox"/> Primary Care Physician Referral
	<input type="checkbox"/> Supervisor Recommendation (Informal)	<input type="checkbox"/> Supervisor Referral (Formal)	<input type="checkbox"/> Mandatory Supervisor Referral	<input type="checkbox"/> Other: _____

Were you referred for a work performance problem? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please indicate the type:	<input type="checkbox"/> Absenteeism / Tardiness	<input type="checkbox"/> Safety / Security	<input type="checkbox"/> Work Relationships	<input type="checkbox"/> Quantity / Quality of Work	<input type="checkbox"/> Positive Alcohol / Drug Test	<input type="checkbox"/> Other

What concerns brought you to the EAP?

What do you want to see happen as a result of coming here?

What have you tried on your own to solve your concerns?

Healthy Habit Information (please base your answers on the past month):	
° Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
° Have you been dieting to lose weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
° Have you smoked cigarettes on a daily basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often in the past month did you drink alcohol? (circle your answer)				
A) I do not drink at all	B) About once a month	C) 2 to 3 times a month	D) 2 to 3 times a week	E) Once a day or more

OPTIONAL:	Education (Years completed or degree earned):	Legal Issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Service: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Branch(es): <input type="checkbox"/> Present <input type="checkbox"/> Past

Client Signature _____

Date _____