Health Promotion Network Employee Assistance Program (EAP)

(Regarding Child Concerns – on back page)

" N/Word/Forms/Questionnaires for Intake/QUESTIONNAIRE-Regarding Child on back page" Rev 8/16

CONFIDENTIAL CLIENT QUESTIONNAIRE: Completion of this questionnaire provides background information that gives the EAP counselor a better understanding of the current issue/concern and the context of your life experience. If you have a concern or question about any item please feel free to leave it blank until you speak with the counselor.

****

QUESTIONS this side REGARDING PARENT / GUARDIAN:

Today's Date: _____

First, Middle, Last Names _____ **Date of Birth:** ___/___/___ **Age**: ____

Social Security #: __XXX_/__XX__/_____ **Gender:** ☐ Male ☐ Female ☐ Other Preference
(We data enter the last 4 SSN digits into computer only.)

The Employer that is providing the EAP Benefit:_____
If this is not your Employer, what is the name of the Employee who works for the above Employer?_____
What is the Employee's relationship to you?_____

Your Employer (Company) _____ Your Job Title _____

Worksite Location/Dept._____ Length of Employment_____

Referred by (self, supervisor, other) _____ Supervisor's Name: _____

Your Mailing Address_____ Your Cell Phone # _____

Your Home Phone # _____

(City/State/Zip)_____

Your Work Phone # _____

Email Address: _____ What is the best way to reach you? _____

If we need to contact you by phone, can we identify our place of business as HPN to whoever answers the phone?
At your primary #: ☐ Yes ☐ No At your home: ☐ Yes ☐ No At your work: ☐ Yes ☐ No

The following Insurance information is requested to aid us in providing you with referrals:

What is the name of your Medical Insurance Company? _____
If you are not the subscriber (policy holder) please provide the following information regarding the Subscriber:
Name _____ Their Relationship to you_____

Education/Family

Years of Education (K-12) _____ College/Vocational Course of Study? _____ Degree/ Cert's._____
Are you a veteran of the Armed Forces? ___Yes ___No Year Enlisted: _____ Year Discharged: _____

What persons are in your household? (alone, spouse/partner, friend, kids, etc)_____
Marital / Relationship status (single, married / partnered, separated, divorced, other) _____
Name of Spouse/Significant Other_____ Length of relationship_____ Length of separation_____

Children / Step Children:
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____
Name:_____ D.O.B.___/___/___ Age_____ Relation:_____ Lives Where_____

Quality Assurance Survey: To ensure that we are providing the highest quality of services, we conduct anonymous confidential surveys. These surveys allow you to evaluate the services you've received at Health Promotion Northwest. Statistical summaries may be shared with employers or other organizations, but please be assured that your confidentiality will not be compromised in any way. Do we have your permission to send a survey to your home through the U.S. Postal Service? ☐ *YES* ☐ *NO*

Please answer the following questions in regard to the child about whom you are most concerned:
The Child's name: _____

Does your child experience any of the following?

___ Difficulty Sleeping	___ Excessive Worry	___ Increased Crying	___ Memory Loss
___ Headaches	___ Bed-Wetting	___ Changes in Weight	___ Restlessness
___ Frequent Stomach Aches	___ Dizziness	___ Fearfulness	___ Nightmares
___ Nail-Biting	___ Increased Irritability	___ Concerns at School	___ Fatigue
___ Withdrawn Behavior			

How many times have you consulted a physician in the past year regarding your child's health? _____

Is your child currently (or in the past year) using prescription medication?
Yes___ No___ Kinds, Dosages & Prescriber_____

Has your child been hospitalized in the past 3 years? Yes___ No___

Has your child ever fractured a bone? Yes___ No___

Do you have concerns about your child regarding any of the following topics?

___ Alcohol	___ Eating Habits	___ Social	___ Discipline
___ Drugs	___ Emotional	___ School	___ Custody
___ Tobacco	___ Family	___ Parenting	___ Other:

Briefly explain checked items:

Does your child have any behavior, habits, or feelings that worry you? Yes___ No___
If yes, briefly explain:

Has your child ever been inappropriately touched or hurt? Yes___ No___

Parent Background/Family History:

I am concerned about my family relationships: Yes___ No___

Who disciplines the children and how? (Briefly explain)

Is there anyone in your child's family who uses alcohol or drugs? Yes___ No___

Are drug or alcohol issues one of the primary issues you want to discuss today? Yes___ No___

Have you consulted a mental health professional in the past year about your family? Yes___ No___
Are you currently seeing a counselor? Yes___ No___ Their Name: _____

What would you like to accomplish with your EAP Counselor? _____
_____
_____
_____