CONFIDENTIAL:
Do not submit with invoices
Fax to 614-566-6846
-or- email to
EAP@OhioHealth.com ONLY

OhioHealth Employee Assistance Program
Client Information Form

Authorization Code: _____

Sex / Gender: _____ Birthdate: __ __/__ __/__ __ __ __ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Client is: _____ an employee of a company with the OhioHealth EAP.

_____ a spouse / partner of an employee with the OhioHealth EAP.

_____ a dependent child of an employee with the OhioHealth EAP.

_____ a dependent other family member of an employee with the OhioHealth EAP.

Department: _____ Job Title: _____

For OhioHealth associates, spouse / partner and dependents, please check one of the following:

__Administration / Corporate
__Berger Hospital
__Doctors Hospital
__Dublin Methodist Hospital
__Emergency Care Centers (free standing EDs)
__Employer Services
__Grady Memorial Hospital
__Grant Medical Center
__Hardin Memorial Hospital
__HomeCare / Hospice
__Mansfield Hospital
__Marion General Hospital
__Nelsonville Health Center
__O'Bleness Hospital
__OhioHealth Physician Enterprise (OPG, MAP, HealthWorks, Mansfield/Shelby/O'Bleness Physicians)
__Pickerington Medical Campus
__Riverside Methodist Hospital
__Shelby Hospital
__Westerville Medical Campus
__Other_____

For non-OhioHealth Associates, please fill out the following:

Company / organization name: _____

Emergency Contact:

Name_____ Relationship to Client: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance: _____

I contacted the EAP primarily because: _____

_____

Severity: On a severity scale of 1 (minimum severity) to 7 (maximum severity), how severe is the problem that brings you to the EAP? Please circle one of the following: **1 2 3 4 5 6 7**

Check (✓) the problem areas that are relevant to your present life circumstance:

_____ Spouse / partner
_____ Child / children
_____ Legal problems
_____ Medical / health
_____ Career / employment
_____ Emotional
_____ Other _____

_____ Alcohol / drugs
_____ Family member using alcohol / drugs
_____ Financial
_____ Aging parent
_____ School-related
_____ Behavioral

Check (✓) the symptoms which describe how you are now feeling:

_____ Physical complaints
_____ Sleep disturbances
_____ Weight changes
_____ Appetite changes
_____ Fatigue
_____ Confusion
_____ Difficulty concentrating

_____ Memory changes
_____ Worry
_____ Hopelessness
_____ Helplessness
_____ Sadness
_____ Irritability
_____ Anger

_____ Paranoia
_____ Decreased pleasure
_____ Increased substance use
_____ Risky behavior
_____ Desire to isolate self
_____ Desire to hurt self
_____ Desire to hurt others

Name of Primary Care Physician: _____ **Physician's Phone:** _____

Current Medications: _____

_____

Check (✓) the work performance factors which are affected by your problem(s):

_____ My problem is not affecting my work performance
_____ Increased absenteeism
_____ Increased tardiness
_____ Difficulty concentrating
_____ Suspended from work

_____ Accidents on the job
_____ No longer employed
_____ Unable to complete assigned tasks
_____ Lateness in completing assigned tasks

_____ Verbal warning from supervisor
_____ Written warning from supervisor
_____ Interpersonal difficulties with:
___ *co-workers* ___ *supervisor*
___ *subordinates*

EAP Demographic Questions

1. **Race / Ethnicity**

_____

2. **Marital Status**

___ Divorced
___ Domestic Partnership
___ Married
___ Single
___ Widowed

3. **Disability Status**

___ Disabled
___ Not Disabled

4. **Caregiving / Financial Responsibility**

___ Children
___ Elders
___ Both Children and elders
___ Other
___ No caregiving / financial responsibility

5. **Military Service**

___ Active Military
___ Reservist / National Guard
___ Veteran
___ None

6. **Work Shift**

___ Day Shift
___ Evening Shift
___ Night Shift
___ Other Shift
___ Weekend only

7. **Work Status**

___ Full Time
___ Part Time
___ Contingent
___ Contract

8. **Position**

___ Business Office Finance / Registration / Clerical
___ 4 year degree required or more, other than RN or Physician
___ Licensed or Technical Personnel (includes LPN)
___ Maintenance
___ Service and Other Clerical (includes PCA / PCT)
___ Physician
___ Resident
___ Registered Nurse
___ Security / Safety Officers
___ Manager
___ Director
___ Senior Leadership (Vice Presidents and above)
___ Nurse Practitioner / Adv. Nurse Practitioner

*Other
_____

For Office Use Only

Authorization Code: _____

Primary Presenting Reason: check one

Child or Adolescent ☐ School ☐ Peers / interpersonal relationships ☐ Parents' marital problems, separation, divorce ☐ Parent-child conflict	Family Relationship ☐ Child ☐ Aging parent ☐ Sibling ☐ Other family member	Emotional ☐ Depression ☐ Anxiety ☐ Anger ☐ Loss / grief
Drugs / Alcohol ☐ Self ☐ Family member	☐ Financial	☐ Medical
☐ Marital / Relationship	☐ Legal	☐ Work / Employment

Provider Name (printed): _____

Provider Signature: _____ **Date:** _____