Case Number_____
(office use only)

EAP Client Registration Form

All information you provide is strictly confidential

Employee Organization: _____

Client Information

Name: _____ Date of Birth: _____

If under 18 yrs., legal guardian name: _____

Relationship to Employee: ☐ Self ☐ Family Member

Home Address: _____
Street City/Town Zip Code

Preferred Phone Number: _____ ☐ Cell ☐ Work ☐ Home

Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian/White
☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Multi Racial ☐ Other

Gender: _____ Pronouns: _____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

*If attending session, spouse/partners' name (see *attached addendum*)

Referred by: ☐ Supervisor ☐ Self ☐ HR ☐ Disability Management ☐ PCP ☐ Coworker ☐ Family
☐ Other - please specify: _____

Have you or a member of your family used EAP services in the past? ☐ Yes ☐ No

Emergency Contact Name and Phone Number: _____

Primary Care Physician Name and Phone Number: _____

Position Title: _____

Insurance Provider: ☐ Aetna ☐ Excellus ☐ Medicaid ☐ MVP ☐ None ☐ Other: _____

Personnel Actions Taken (employee only): ☐ Counseled ☐ Warning ☐ Suspension ☐ Demotion
☐ Termination ☐ Resignation ☐ None ☐ Other

UR Employee Information

(DO NOT complete if you are not employed by UR)

Work Location: ☐ River Campus ☐ Tech Park ☐ URMC ☐ UR Other Union Member: ☐ Yes ☐ No

Work Status: ☐ FT ☐ PT ☐ Temp ☐ Per Diem ☐ Volunteer ☐ Resident/Fellow

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EAP Pre-Screen Survey

1. Briefly explain why are you seeking EAP services :_____
_____
_____
_____
_____

2. The following is a list of general symptoms that people may experience. Please check all that you have experienced over the last 1-4 weeks.

- ☐ Repetitive, senseless thoughts behaviors
- ☐ Irrational thoughts
- ☐ Sad/depressed/down in the dumps
- ☐ Trembling/shakiness
- ☐ Aggressive/violent behavior
- ☐ Constant worry/fear
- ☐ Irritability
- ☐ Tense/nervous/cranky
- ☐ Feeling in a dreamlike state
- ☐ Concentration difficulties
- ☐ Memory problems
- ☐ Sweating
- ☐ Dizzy/lightheaded
- ☐ Insomnia/trouble sleeping
- ☐ Sleeping too much
- ☐ Fatigue/lack of energy
- ☐ Decrease in motivation
- ☐ Fear of losing control
- ☐ Fear of going crazy
- ☐ Change in weight
- ☐ Helpless feelings
- ☐ Frequent crying/weeping
- ☐ Frequent thoughts of suicide/death
- ☐ Fear of impending doom
- ☐ Worthless feelings
- ☐ Hopeless Feelings
- ☐ Lack/loss of interest in things
- ☐ Feelings like is not worth living
- ☐ Decrease in sex drive
- ☐ Frequent negative thinking
- ☐ Fear of dying
- ☐ Seeing things that are not real
- ☐ Hearing things that are not real

3. How many times have you been unexpectedly absent or tardy in the last 30 days due to physical or mental health reasons? ☐ No Days ☐ 1-5 Days ☐ 6-10 Days ☐ 11-15 Days ☐ 16+ Days

4. How did you hear about EAP services?

- ☐ HR
- ☐ Website
- ☐ Brochure/Poster
- ☐ Family Member
- ☐ HRBP
- ☐ BHP
- ☐ Reputation
- ☐ Union Rep
- ☐ PCP
- ☐ Orientation/Presentation
- ☐ Condition Management
- ☐ Other (please specify): _____
- ☐ Supervisor
- ☐ Co-Worker
- ☐ Lifestyle Program
- ☐ Biometric Screening
- ☐ Attended EAP Previously

5. Is the reason you are seeking EAP services work related?

- ☐ Work related concern that **is** impacting my personal life
- ☐ Work related concern that **is not** impacting my personal life
- ☐ Personal concern that **is not** impacting my work performance
- ☐ Personal concern that **is** impacting my work performance

6. If your concern is impacting your work performance, which of the following work performance issues have you experienced in the past 12 months?

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☐ Not impacting work performance
☐ Quality/Quantity of work decreased
☐ Resulted in the use of sick time
☐ Problem relating to other employee
☐ Other (please specify): _____

7. During the last four weeks, how much difficulty have you had doing your work or other regular daily activities as a result of you physical health?
   ☐ None at all ☐ A little bit ☐ Some ☐ Quite a bit ☐ Could not do daily work

8. During the last four weeks, to what extent have you accomplished less than you would like in your work or in other daily activities as a result of emotional concerns (such as feeling depressed or anxious)?
   ☐ None at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

9. During the last four weeks, to what extent has your physical or emotional health concerns interfered with your normal social activities with family, friends, neighbors or groups?
   ☐ None at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

10. Have you had any acts of violence directed against you? ☐ Yes ☐ No

11. How many alcoholic beverages do you consume each week? _____

12. Do you use recreational drugs or substances? ☐ Yes ☐ No

13. Are you currently on any medications? _____

14. Are you a veteran? ☐ Yes ☐ No

15. Do you have a disability that you would like us to be aware of? ☐ Yes ☐ No
    Reasonable accommodations needed for your session: _____

16. Was your call/email to EAP answered promptly?
    ☐ Yes, immediately ☐ Yes, within an 8 hour timeframe ☐ No

17. Was your appointment scheduled in a timely manner?
    ☐ Yes, within 3 business days ☐ No, I requested a specific date, time and/or counselor
    ☐ Yes, within 5 business days ☐ No appointment was available within 5 days

18. Would you have taken time off from work to deal with your concerns if EAP were no available?
    ☐ Yes ☐ No

19. If EAP were not available, where would you go to seek assistance? (please check only one)
    ☐ Family member/Friend ☐ Supervisor/Co-worker ☐ PCP
    ☐ Professional in the community ☐ I wouldn't know where to go
    ☐ Behavioral Health Partners (UR only) ☐ Other (please specify): _____

20. Are you interested in receiving our EAP newsletter? ☐ Yes ☐ No

    If so, please include the email address that you would like the newsletter to be delivered to:

    _____