GUNDERSEN HEALTH SYSTEM EMPLOYEE ASSISTANCE PROGRAM

CHILD & ADOLESCENT INFORMATION FORM

Please fill out this form as completely as possible. All information is kept **confidential** and used only for evaluating our program.

Company providing EAP benefit: _____ Date: _____

Name: _____ Birth date: _____ Age: _____

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

Home phone: ( )_____ Name of Parent(s)/Guardian you live with:_____

1. Are you presently in School?
____Yes ____No

If yes, Grade_____

If Yes, Name of School_____

2. Identify Gender
____ Male ____ Female ____ Other

3. Who is attending this session?

____Self
____Self & Family Member(s)
____Self & Other

Specify_____

4. Who referred you to EAP?

____Self
____Family member
____Physician
____Other

5. Who do you currently live with?

____Mother & Father
____Mother & Stepfather
____Father & Stepmother
____Mother
____Father
____Stepmother
____Stepfather
____Legal Guardian
____Foster Parent
____Other Relative

Specify_____

6. Are you employed or do you volunteer? ____Yes ____No

If yes, where? _____

Number of hours worked or volunteered in a week? _____

How long have you worked or volunteered for this place? _____

7. Have you used EAP previously?
____Yes ____No

8. Have you ever been to a counselor in the past?
____Yes ____No

If yes, explain: _____

9. Are you currently seeing a counselor?
____Yes ____No

10. What do you like to do for fun and/or relaxation?

_____

_____

11. In the last 6 months have you had any of these school performance problems?

____Absent
____Unexcused Absence
____Tardy
____Skipping Classes
____Suspension
____Expelled
____Change in Grades
____Detention
____Problems with Friends
____Bullying

12. Has your school taken any of the following actions in regard to you?

____Counseled you on school problems
____Given a verbal/written warning
____Suspended you
____No actions taken
____Other

13. How many days have you been absent in the last school year?

____No days
____1 - 5 days
____6 - 10 days
____11 - 15 days
____16 or more days

14. Have you lost time at work or school due to an injury or illness in the in the past 6 months?
____Yes ____No

If yes, what was the injury or illness?
_____

15. Have you ever tried any of the following substances?

____Alcohol
____Marijuana/Synthetic Marijuana
____Cocaine/Crack
____Huffing/Inhalants
____Methamphetamine/Stimulants
____Heroin
____Tobacco/e-Cigarettes
____Medication of someone else
____Caffeine

16. Indicate Primary Concern with #1 and Secondary Concern with #2. Check any others that apply.

____Relationship problem(s)
____Family problem(s)
____Emotional difficulties
____Depression
____Drug use
____Alcohol use
____Family member's use of alcohol
____Family member's use of drugs
____Eating problems
____Grief and loss
____Health problems
____School related
____Legal problems
____Sexuality
____Stress
____Other: _____

17. How would you rate your present health?
____Excellent ____Good
____Fair ____Poor

18. What health problems have you had in the past?

_____
_____
_____

19. If you are currently on any medications, please list them below:

Medication_____
Reason_____

Medication_____
Reason_____

20. Do you have Health Insurance Coverage? ____Yes ____No

Name of Company_____
Name of Insured_____

OVER

STATEMENT OF UNDERSTANDING

Welcome to the Gundersen Health System Employee Assistance Program (EAP). Being able to share a problem can do much to lessen the stress you may be experiencing. We provide employees and their family members with free, confidential assessment, short-term counseling, and referral services. This service is intended to assist employees and family members who, voluntarily, seek assistance to resolve personal problems that may be affecting their health, well-being, and/or job performance. Your employment or job advancement will not be affected as a result of your participation in the EAP. The following will provide you with basic information regarding your EAP and inform you of your rights and responsibilities as a client.

QUALITY OF SERVICE: All EAP consultants possess an appropriate level of education, training and experience necessary to provide high quality EAP assessment and referral services to you. Please feel free to ask your consultant about his/her credentials. The EAP staff will take your needs into consideration and uphold your personal dignity as they work with you. Because we believe it is important for you to find the right match with your EAP consultant, please contact the EAP office should you wish an alternate consultant. In addition, should you be dissatisfied with the service(s) you have received, please contact the EAP office assistant for grievance procedure guidelines.

FEES: Sessions with a consultant are offered at no direct cost to you or your family members. If you choose to accept a referral to another individual or agency, any financial charges will be your responsibility. Many services are available on an ability-to-pay basis or may be covered by your health insurance. While the EAP consultant will offer some assistance, it is your responsibility to determine whether or not such services are covered under your insurance plan.

PRIVACY: Information concerning your use of the EAP will not be given to anyone outside the EAP without your permission unless required by law. Certain state laws require that the EAP staff assume the responsibility for reporting to appropriate parties in instances when a person is a danger to him or herself, to others, or when a child or vulnerable adult abuse/neglect is involved.

OFFICE HOURS: EAP is available Monday through Friday. During regular business hours, the EAP office assistant can assist you with the scheduling of an appointment or in leaving a message for your consultant. After hours, on weekends, or holidays, EAP clients can call the EAP office at 608-775-4780 or 800-327-9991 and talk directly with the EAP back-up consultants. Should you or a family member need to see a consultant in person, you will be assisted in making those arrangements.

SUMMARY: If you have questions or concerns about the above information, please ask your EAP consultant or contact the EAP office.

I have read this Statement of Understanding in its entirety and do understand its content.

_____ _____

Client or Legal Guardian Signature Date