Aurora Employer Solutions
Employee Assistance Program

Aurora Health Care®

Client Information Form

Client Name: _____ Date: _____

What is the concern that brought you to EAP?_____

_____

_____

Is this issue causing difficulty at work? ❒ Yes ❒ No

Please circle to what degree:

All the Time Often Sometimes Rarely Never

Is this issue causing problems in your personal life? ❒ Yes ❒ No

Please circle to what degree:

All the Time Often Sometimes Rarely Never

Check any of the problems or symptoms you have had recently.

❒ Anxiety	❒ Changes or problems in eating	❒ Headaches	❒ Tearfulness
❒ Nervousness	❒ Changes or problems in sleeping	❒ Fatigue/Tiredness	❒ Chronic pain
❒ Depression	❒ Sexual difficulties	❒ Irritability	❒ Other
❒ Fears	❒ Difficulty concentrating	❒ Loss of interests in usual activities	

ABOUT YOU

Have there been any recent illnesses or deaths among your family or close friends?	❒ Yes	❒ No
Have there been any recent crises or major changes in your life?	❒ Yes	❒ No
Have you ever experienced any emotional, physical, or sexual abuse?	❒ Yes	❒ No
Have you ever intentionally hurt yourself or made a suicide attempt?	❒ Yes	❒ No
Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions?	❒ Yes	❒ No
Is there a history of mental illness in your family?	❒ Yes	❒ No
Are you in a situation where you experience domestic violence?	❒ Yes	❒ No
Have you been in counseling or psychotherapy before?	❒ Yes	❒ No
Have you had any hospitalization(s) for emotional problems?	❒ Yes	❒ No

ABOUT YOUR FAMILY

Family member (spouse/partner/children) and those living in your household:

1. First Name/Relationship: _____Age _____ Home/Away (circle one)
2. First Name/Relationship: _____Age_____ Home/Away (circle one)
3. First Name/Relationship: _____Age_____ Home/Away (circle one)
4. First Name/Relationship: _____Age_____ Home/Away (circle one)
5. First Name/Relationship: _____Age_____ Home/Away (circle one)
6. First Name/Relationship: _____Age_____ Home/Away (circle one)

Please name any people or organizations that provide help and support to your family:

YOUR MEDICAL HISTORY

Have you had a medical exam in the past year? ❒ Yes ❒ No
Do you have a Primary Care Physician (PCP)? ❒ Yes ❒ No
Are there any current or past medical conditions or disabilities that would be helpful for us to know about? _____

_____

_____

Are you taking any medications? ❒ Yes ❒ No
If yes, list:

OTHER ISSUES

Alcohol and Other Drugs

Are you concerned about your alcohol use? ❒ Unsure ❒ Yes ❒ No

How often do you drink? _____ How many drinks at a time? _____

Are you concerned about your marijuana use? ❒ Unsure ❒ Yes ❒ No

If you use, how often? _____

Are you concerned about your over-use of prescriptions, such as pain relievers? ❒ Unsure ❒ Yes ❒ No
Are you concerned about your use of other drugs? ❒ Unsure ❒ Yes ❒ No
Is someone who cares about you concerned about your alcohol or drug use? ❒ Unsure ❒ Yes ❒ No
Was alcohol, prescriptions or other drugs an issue in the past? ❒ Yes ❒ No

Are you concerned about the drug or alcohol use of someone close to you? ❒ Yes ❒ No
Did you grow up in a home in which a parent abused drugs or alcohol? ❒ Yes ❒ No

Are you concerned about or do you want to quit tobacco? ❒ Unsure ❒ Yes ❒ No
How much caffeine do you have in a day? _____

Legal

Do you have legal concerns? ❒ Yes ❒ No
Have you ever been arrested? ❒ Yes ❒ No
Have you ever been involved with Child Protective Services? ❒ Yes ❒ No

Financial

Are you experiencing any financial difficulties? ❒ Yes ❒ No
Is gambling affecting your life? ❒ Yes ❒ No

Work and School

What is your job/profession? _____

Length of time at your current job: _____

Are you currently enrolled in school? ❒ Yes ❒ No

Highest education level completed: _____

OPTIONAL INFORMATION

Relationship Status: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Living Together

Racial Identity: ❒ Caucasian ❒ African American ❒ Hispanic ❒ Bi-Racial ❒Asian American
❒ Native American ❒ Other: _____