Date: ________________________ Prior EAP Contact: Yes_____ No_____

PERSONAL INFORMATION QUESTIONNAIRE

ALWAYS COMPLETELY CONFIDENTIAL

Date of Birth__________________

Home phone__________________

Cell Phone#__________________

Name ________________________ Age:______ Sex: M____ F____

Address:________________________ City________________ST________ Zip Code____________

Company Name that Benefit is through:____

Emergency Contact (Name) ________________________ Phone#____________________

FAMILY / MARITAL HISTORY

(if not applicable skip to next section)

Married____ If yes- How many times?____ Single____ Separated____ Divorced____ Widowed____ Engaged____ In a Relationship____

How long have you been in your current relationship? ______________

List name, age, and relationship of persons with whom you now live.

Name(s): First & Last	Age	Relationship

Are there problems with children out of the home (visitation / support)?____________________ ____________________

continued on back........

OCCUPATION (if not applicable skip to next section)

Employer?____Position____________________ How Long_____________

Does your present work satisfy you? Yes____ No____ (If no, in what ways are you dissatisfied?)____________________

Has your work performance decreased recently? Yes____ No____ Performance problems? Yes____ No ____

Are you involved in a discipline process? Yes____ No____ Did HR or Supervisor refer you to EAP?________________

Military Service - Service / associated problems? ____

CURRENT PROBLEM

Are you concerned about any of the following? Circle areas of concern

Abuse-Domestic/Emotional/Physical/Sexual
Alcohol/Drugs-self or other
AODA Assessment-failed drug/alcohol test or self
Emotional- Anger/Anxiety/Depression/Grief/Stress/Trauma
Family Issues-Blended Family/Child Custody/Childcare/Eldercare/Family Counseling/Parenting/School
Financial Problems-Budgeting/Gambling
Legal problems-past/present
Medical-Eating Disorder/Illness/Injury/Post Traumatic Disorder/Smoking
Relationship-Family Member/Divorce/Marital/Significant Other
Suicide-Self or Other
Work-Career Options/Harrassment/Performance Problems/Relations Conflict/Stress/Suspended/Terminated

Please describe the Primary Problem(s) for which you are now seeking help in detail:

When did problems begin? ________________________ How is the problem(s) affecting your life?________________

What, specifically, would you want from treatment here? ____

For Organizational Use – May Affix Sticker:
Patient Name: ______________________
Medical Record #: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Affinity Health System has given you a copy of it's Notice of Privacy Practices explaining:

- Our privacy practices for using and disclosing your health information
- Your privacy rights with regard to your health information

We must try to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

______________________________________ ______________________
Patient/Legal Representative Signature Date

Staff member should complete if Acknowledgement Form was not signed by patient/legal representative:

1. Does patient have a copy of the Privacy Notice?

   - ❑ Yes
   - ❑ No – Why: ______________________

2. Please explain why the patient was unable to sign an acknowledgement form or why it was not possible to obtain the patient's signature:

   - ❑ Patient/Legal Representative Left Before Signature Obtained
   - ❑ Emergency/Urgent Admission With Patient Not Present for Registration
   - ❑ Patient By-passed Registration – Not Available
   - ❑ Patient Unable to Comprehend
   - ❑ Patient Communication Barrier Existed
   - ❑ Legal Representative (Guardian) of Patient Not Available
   - ❑ Other: ______________________

3. Completed By: ______________________

Patient Acknowledgement Updated in System:	❑ Yes
Route Completed Form To:	

AFFINITY HEALTH SYSTEM **Statement of Understanding for our Clients**

To our clients:

We are pleased that you have decided to use your Employee Assistance Program. There are several things we want you to know before we begin discussing your reason for being here.

Promise to Client

Affinity Occupational Health EAP promises to provide our clients with personalized care through our partnership approach. Through active listening and counseling, we will help you define and move beyond your concerns. Our counseling process will use a positive, solution-focused approach to give you the tools you need to develop an action plan that leads to a positive resolution. At all times, we promise to create an open and empathetic environment that encourages personal growth

Problems are sometimes very hard to talk about. That is why confidentiality has to be as important for us as it is for you. We take every precaution to protect the confidentiality of your visit with us and we hope that you will do the same. We do not discuss your situations outside our offices or send records to anyone unless you give us written permission. There are four exceptions to the rule:

1. If we learn about child abuse or neglect, or abuse, neglect or exploitation of incapacitated adults, we are required by law to report it to the Wisconsin Department of Human Services.
2. If, in our judgment, an EAP client is dangerous to themselves or others, we will disclose information to help protect a person from harm.
3. If we are required to present records of testimony to comply with a court order, it is our legal responsibility to comply.
4. In the event that your employer requests confirmation that you have seen an EAP counselor, we will request that you sign a Release of Information prior to disseminating that information.

Occupational Health Systems staff may follow up with you by phone or questionnaire to evaluate program effectiveness and to coordinate care. ____Yes or ____ No

Services and Related Rights:

1. To be treated with dignity and not to be discriminated against.
2. To give informed consent prior to receiving service.
3. To receive prompt and adequate services.
4. To refuse any services or recommendation.
5. To be informed about the results of assessments and recommendations.

If you feel that your rights have been violated, we encourage you to:

1. Discuss the matter with your local EAP counselor.
2. If unresolved, call Lisa Kogan-Praska, Director, Employer Solutions and Urgent Care at (800) 541-0351.

We want to provide a safe and comfortable place for you to discuss your problems with us. We will listen, help you with an assessment of your concerns and then develop a plan of action. The plan of action may include a referral to an appropriate source of help. For example, while we do not offer long-term outpatient counseling or expert testimony, should you need these services, we can refer you to someone who does.

The EAP services are provided at no cost to you. However, if a referral to another agency is appropriate, the cost for these services will not be covered by the Employee Assistance Program. While we attempt to maintain up-to-date information about your health plan so we can refer to covered providers, it is your responsibility to verify your insurance coverage and to follow the procedures outlined in your policy. If you must cancel or post-pone, **we expect you to give us 24 hours notice.**

EAP Client Signature______________________________________ Date____________________

EAP Counselor____ Date____________________

1550 Midway Place, Menasha & 2700 W. 9th Ave, Oshkosh (920)720-1090 or (800)894-9327

***The EAP will retain all records for a period of 7 years after the file is closed per Wisconsin Regulations~*