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INFORMATION FORM FOR EMPLOYEE ASSISTANCE PROGRAM (EAP) CLIENTS

Today's Date: _____ Client Name: _____ Date of Birth: _____

Cell Phone: _____ E-mail: _____

Occupation: _____

Home Address: _____ Employer: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Circle one: Single Paired Married Separated Divorced Remarried Widowed

For couples counseling:

Spouse/Partner Name: _____ Date of Birth: _____

Cell Phone: _____ E-mail: _____

Occupation: _____

Home Address: _____ Employer: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

If you have children, please identify them below. If you do not have children, please skip this section. **For family counseling, circle the names of children, if any, who will be included in treatment.**

Name(s) of children	Birth Date(s)	School(s), if any
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- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

HEALTH INSURANCE INFORMATION

During or at the conclusion of your allocated EAP sessions, Dr. Gum may discuss with you whether ongoing counseling may be helpful to you. To assist in locating potential counselors and if your insurance plan covers mental health treatment, please fill out the following:

Name of Insurance Carrier: _____ Name of Insured: _____

ID #: _____ Group #: _____ Other insurance? Yes No

If yes: Name of Insured, Other Policy: _____ Name of Other Carrier: _____

ID # of Other Policy: _____ Group # of Other Policy: _____

If your health insurance does not cover mental health treatment, Dr. Gum will discuss affordable alternatives with you.