

**EMPLOYEE ASSISTANCE PROGRAM**

**Arlington Public Schools  
Arlington County Government  
2847 Wilson Blvd.  
Arlington, Virginia 22201-3803  
TEL (703) 228-8720 - FAX (703) 875-2185**

**CLIENT INFORMATION RECORD**

**Name:** Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Previous Last Name: \_\_\_\_\_

**Organizational Status** (Please check the relevant):

Employee      Family Member/Dependent      Retiree      Other

If you are not the employee, please complete this section:

**Employee's Name:** Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**Home Phone Number:** (\_\_\_\_) \_\_\_\_\_      **Work Phone Number:** (\_\_\_\_) \_\_\_\_\_

Ok to call?:    Yes    No

Ok to call?:    Yes    No

Ok to leave a message?:    Yes    No

Ok to leave a message?:    Yes    No

**Cell Phone Number:** (\_\_\_\_) \_\_\_\_\_    Ok to call?:    Yes    No    Ok to leave a message?:    Yes    No

**\*Your permission is requested to leave messages and/or send email.**

**Email Address:** \_\_\_\_\_      Ok to email?:    Yes    No

**Home Address:** Number & Street: \_\_\_\_\_

City, State & Zip Code \_\_\_\_\_

**Gender:**    Male    Female

**Date of Birth:** \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

**Race/Ethnic Origin:**    African-American    Asian/Pacific Islander    Caucasian    Hispanic/Latino  
Native American Indian      Other Race/Ethnic Origin: \_\_\_\_\_

**Marital Status:**    Married      Single/Never Married      Separated      Divorced  
Widowed      Other Marital/Relationship Status

**Number of Children:** \_\_\_\_\_      **Number of Dependents:** \_\_\_\_\_

**Number of Household Members:** \_\_\_\_\_

**Educational Level:**    Elementary/Middle School    High School    SomeCollege/Technical School  
Associate Degree/Technical Degree    Bachelor's Degree    Master's Degree    Doctoral Degree

**Insurance Plan:**

- **APS:**    Cigna      Kaiser Permanente      No Health Plan

- **ACG:**    Cigna      Kaiser Permanente      No Health Plan

If none of the above, are you covered under another insurance plan? Yes No

Name of Other Plan: \_\_\_\_\_

**Employer:**      Arlington Public Schools (APS)      Arlington County Government (ACG)

**Name of the School/Division or Department:** \_\_\_\_\_

**What is your Work Location/Site?** \_\_\_\_\_

**Please circle your employment status:**      Full-time      Part-time      Temporary      Other

**What is your job title?** \_\_\_\_\_

**Does your position require a Commercial Driver's License?**      Yes      No

**Please indicate your work shift:**      Does not work shifts      Day      Evening      Night      Rotating      Other

**How many years have you been with your current employer?** \_\_\_\_\_

**Please rate your current work performance on a scale of 1-10, with 10 being the highest** \_\_\_\_\_

**Are you a union member?**      Yes      No      If yes, name of the Union: \_\_\_\_\_

**Is this regarding a worker's compensation claim?**      Yes      No

**Primary Referral Source** (Who told you about the EAP?):

Self-Initiated      Family Member      Co-Worker      Principal/Asst.Principal \_\_\_\_\_ (Name)  
 Supervisor/Manager \_\_\_\_\_ (Name)      HR/Personnel      Medical/Health Department      OSHA  
 DOT      Union Rep      External Resource Provider      Other

**If you are a Self Referral, how did you hear about us?**

Newsletter      Website      Orientation      EAP Training      Used EAP in Past

**What brings you to the EAP?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### For Office Use Only

**Date:** \_\_\_\_\_      **ROI:** Yes \_\_\_ No \_\_\_

**Primary EA Professional:** \_\_\_\_\_

**Date Case Opened:** \_\_\_\_\_

**Prior EAP Participation:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Entered in EapiSoft:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Did client receive the satisfaction questionnaire:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Case Closed:** Yes \_\_\_\_\_ No \_\_\_\_\_