



EMPLOYEE ASSISTANCE PROGRAM

Initial Visit Client Questionnaire

**The information you are about to provide is strictly confidential.
It cannot and will not be released or disclosed to anyone outside of the EAP without your consent
except as explained in the attached Statement of Understanding.**

Your name _____ Initial meeting date _____

Mailing address _____ City _____ Zip _____

Please provide at least one phone number where we can contact you as necessary:

Home _____ Best time to call _____ Okay to leave message? Yes No

Work _____ Best time to call _____ Okay to leave message? Yes No

Cell/other _____ Okay to leave message? Yes No

Last 4 numbers of your SSN- _____ Age _____ Sex _____ Last grade completed _____

Are you: Never married Married/domestic partner Sep/divorced Widowed

Job Title _____ Dept _____ Years employed at KC _____ Union # _____

Who referred you to the EAP? Myself Supervisor Co-worker Other: _____

If referred by your supervisor, his/her name _____

Have you ever been to the King County EAP before? Yes No

If yes, about how long ago? _____ Whom did you see? Pam Wyss Tom Friedel Tony Hansen

From the generalized list below, please check the issues for which you are seeking EAP assistance:

Co-worker(s)	Drug/alcohol	Family	Stress
Subordinate(s)	Legal	Domestic violence/abuse	Depression
Supervisor(s)	Financial	Workplace harassment/abuse	Other

Please briefly explain a little more about the current issues

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