Self-Referral EAP Client Packet

YOUR WORKPLACE WELLNESS & EAP PARTNER

H&H HEALTH ASSOCIATES® 25th ANNIVERSARY

EAP INTAKE INFORMATION

CLIENT INFORMATION			
Last name	First name	Middle	DOB

Contact phone number:	Okay to leave message: ☐ Yes ☐ No

Emergency Contact:	Relationship to you:	Contact phone number:

EAP Services are available to me through:	Company name:

This is my employer ☐	This is my spouses employer ☐	I am a dependent ☐	Other ☐ Explain:

GENERAL BACKGROUND
What brings you to the EAP today?

PERSONAL ASSESSMENT:				
Recently I have had job performance difficulties:	None ☐	Slightly ☐	Moderately ☐	Frequently ☐
Recently I have had difficulty with normal social activities:	None ☐	Slightly ☐	Moderately ☐	Frequently ☐
My current physical health is:	Excellent ☐	Good ☐	Fair ☐	Poor ☐

How many days of work have you missed or been tardy in the past month?
What is your occupation:
Married/Separated/Divorced (dates):
Dependent(s) Name(s)/age(s):
Medical Conditions and Medications:
Dates, duration, and providers of all past counseling:

Only if applicable:

I (we) give consent to H&H Health Associates to provide counseling services for: _____

(Minor child)

Guardian(s) Signature:

I acknowledge that a "Statement of Understanding-Employee Assistance Services" was provided to me and any questions I had were answered to my satisfaction.	Initial
I acknowledge that a "Notice of Privacy Practices H&H Health Associates, Inc." (HIPAA Policy) was provided to me and any questions I had were answered to my satisfaction.	Initial
Signature:	**Date:**

40 Question Survey

INSTRUCTIONS: READ EACH ITEM BELOW CAREFULLY AND DECIDE *HOW MUCH* YOU HAVE EXPERIENCED EACH SYMPTOM *IN THE LAST MONTH. CIRCLE* THE APPROPRIATE RESPONSE.

0= Not at all 1= A little bit 2= Moderately 3= Quite a bit 4= Extremely

1. Headache	**0**	**1**	**2**	**3**	**4**
2. Nervousness or shakiness inside	0	1	2	3	4
3. Feeling critical of others	**0**	**1**	**2**	**3**	**4**
4. Trouble remembering things at work	0	1	2	3	4
5. Feeling easily annoyed or irritated	**0**	**1**	**2**	**3**	**4**
6. Feeling low in energy or slowed down	0	1	2	3	4
7. Feeling that most people can not be trusted	**0**	**1**	**2**	**3**	**4**
8. Poor appetite	0	1	2	3	4
9. Crying easily	**0**	**1**	**2**	**3**	**4**
10. Temper outbursts that you could not control	0	1	2	3	4
11. Blaming yourself for things	**0**	**1**	**2**	**3**	**4**
12. Feeling blocked in getting things done	0	1	2	3	4
13. Feeling lonely	**0**	**1**	**2**	**3**	**4**
14. Worrying too much about things	0	1	2	3	4
15. Feeling no interest in things	**0**	**1**	**2**	**3**	**4**
16. Feeling fearful	0	1	2	3	4
17. Your feelings being easily hurt	**0**	**1**	**2**	**3**	**4**
18. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
19. Feeling that people are unfriendly or dislike you	**0**	**1**	**2**	**3**	**4**
20. Heart pounding or racing	0	1	2	3	4
21. Feeling inferior to others	**0**	**1**	**2**	**3**	**4**
22. Drinking more alcohol than usual	0	1	2	3	4
23. Trouble falling asleep	**0**	**1**	**2**	**3**	**4**
24. Having to check and double-check what you do	0	1	2	3	4
25. Difficulty making decisions	**0**	**1**	**2**	**3**	**4**
26. Your mind going blank	0	1	2	3	4
27. Trouble concentrating at work	**0**	**1**	**2**	**3**	**4**
28. Overeating	0	1	2	3	4
29. Sleep that is restless or disturbed	**0**	**1**	**2**	**3**	**4**
30. Difficulty getting the job done	0	1	2	3	4
31. Having urges to break or smash things	**0**	**1**	**2**	**3**	**4**
32. Feeling very self-conscious with others	0	1	2	3	4
33. Others not giving you proper credit for your achievements	**0**	**1**	**2**	**3**	**4**
34. Shouting or throwing things	0	1	2	3	4
35. Feeling pushed to get things done	**0**	**1**	**2**	**3**	**4**
36. Thoughts of ending your life	0	1	2	3	4
37. Never feeling close to other persons	**0**	**1**	**2**	**3**	**4**
38. Feelings of guilt	0	1	2	3	4
39. Needing a medication or using drugs more	**0**	**1**	**2**	**3**	**4**
40. Having problems with co-workers	0	1	2	3	4

Informed Consent to Treatment

The purpose of this form is to acknowledge voluntary consent to treatment by the clinician assigned to you by St. Louis Counseling & Wellness listed below. By signing this form you are agreeing with the following:
I acknowledge that I am voluntarily receiving service from _____.
I understand that I can discontinue services at any time. (therapist's name)
I understand that information shared with the named clinician will be held in the strictest of confidence. I give my permission for the following disclosures of information:

- CLINICAL SUPERVISION: To ensure quality of care, I understand that my information may be discussed with a clinical supervisor to assist in clinical development with the intent to improve clinical services.
- AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I authorize St. Louis Counseling & Wellness to release all necessary information to any insurance company, employee assistance program, health plan or other entity (third party payor) which may be responsible for paying for my care. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to St. Louis Counseling & Wellness and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
- PAYMENT FOR SERVICES: In return for services to be provided by St. Louis Counseling & Wellness, I promise to pay for services rendered by St. Louis Counseling & Wellness to me or for my benefit. If the services I receive from St. Louis Counseling & Wellness are covered by a third party payor (EAP, insurance, etc.), St. Louis Counseling & Wellness may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

I understand that my information may not be released without my written consent with the following exceptions:

- I present a danger to myself or someone else
- Actual or suspected child abuse or neglect. (Clinician named above is a mandated reporter.)
- Valid court order requesting records
- Appropriate discussion of case with other professionals for consultation or supervision

I agree to pay an appointment fee of $60 if I fail to give 24 hour notice to cancel an appointment.
_____ (initial here) ***Does not apply while using EAP sessions.***

I acknowledge that I have received a copy of "Notice of Privacy Practices" with this Informed Consent to Treatment. I may revoke this consent in writing at any time.

_____	_____	_____
Client's Printed Name	Client's Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date

Client Satisfaction Survey

Thank you for completing the Client Satisfaction Survey.
We would like to know your level of satisfaction with H&H Health Associates' services. Please take a few minutes to share your opinions. Your responses are confidential and individual ratings will not be reported.

By mail: H&H Health Associates, Inc.
3660 South Geyer Road
Suite 100, Laumeier III
St. Louis, MO 63127
By fax: **314.845.8087**
By email: www.hhhealthassociates.com and click on the contact tab or to counsel@hhhealthassociates.com

Please rate your satisfaction level with each of the following statements.

1 = completely satisfied/agree
2 = mostly satisfied/agree
3 = dissatisfied/disagree
4 = N/A

Services

1.	Counseling was at a convenient time and location for me.	☐ 1	☐ 2	☐ 3	☐ 4
2.	Help-line staff were courteous, professional, and knowledgeable.	☐ 1	☐ 2	☐ 3	☐ 4
3.	I was served in a confidential manner.	☐ 1	☐ 2	☐ 3	☐ 4
4.	I recommend that the service continue to be made available.	☐ 1	☐ 2	☐ 3	☐ 4
5.	I would use the service again.	☐ 1	☐ 2	☐ 3	☐ 4

My counselor was:

6.	Helpful.	☐ 1	☐ 2	☐ 3	☐ 4
7.	A good listener.	☐ 1	☐ 2	☐ 3	☐ 4
8.	Understanding of my concerns.	☐ 1	☐ 2	☐ 3	☐ 4
9.	Professional.	☐ 1	☐ 2	☐ 3	☐ 4

Counselor's name: _____

Company

10.	Overall, how satisfied are you with H&H Health Associates, Inc. as a company?	☐ 1	☐ 2	☐ 3	☐ 4

11. How can H&H Health Associates, Inc. improve your customer experience?

Your feedback helps us continually improve H&H Health Associates' services to you.

If you'd like to speak with someone from H&H, you may contact Tim Hobart, CEO at 314.845.8302, ext. 207