CLIENT DEMOGRAPHIC FORM

Client Company Name: **Division/Department:**
Employee Name: **SSN#:**
DOB:
Non-work E-mail: **Cell Phone:**
Address: **City:** **State:** **Zip:**

EMPLOYEE INFORMATION ONLY

Case Status

- ◯ New
- ◯ Re-opened
  Last Time Seen:

Ethnic Origin

- ◯ White
- ◯ Black
- ◯ Hispanic
- ◯ Asian
- ◯ Native American
- ◯ Other_____

Marital Status

- ◯ Married
- ◯ Single
- ◯ Separated
- ◯ Divorced
- ◯ Widowed
- ◯ Significant Other

Education (Highest completed)

- ◯ Grade School
- ◯ High School
- ◯ Technical School
- ◯ College
- ◯ Graduate School

Information Source
(How did you know about EAP?)

- ◯ Home Mailing
- ◯ Brochure/ Poster
- ◯ Training Session
- ◯ Family Member
- ◯ Supervisor
- ◯ Co-worker
- ◯ Other

Referral Source
(How were you referred?)

- ◯ Self Referral
- ◯ Supervisory Referral
- __Suggestion
- __Required
- ◯ Family Initiated
- ◯ Company Wellness/ Medical Dept.
- ◯ Other_____

Employee's Job Category

- ◯ Executive/Mgmt.
- ◯ Professional/ Technical
- ◯ Sales/Marketing
- ◯ Clerical
- ◯ Labor/Manufacturing
- ◯ Other_____

Employee Status

- ◯ Active
  Length of Service:
  ___Years:___Months:
- ◯ Inactive
- ◯ Retired

NON-EMPLOYEE INFORMATION ONLY

Name: **Relationship to Employee:**
SSN: **DOB:** **Ethnicity:**
Gender:
Home Address: **City:** **State:**
Zip:

Name: **Relationship to Employee:**
SSN: **DOB:** **Ethnicity:**
Gender:
Home Address: **City:** **State:**
Zip:

INSURANCE COMPANY: _____ **PHONE:**_____

AUTHORIZATION NUMBER (IF NEEDED):_____