

Child/Adolescent Information Form

Date _____

Name of Child/Adolescent _____ Date of Birth _____

Child/Adolescent School _____ Grade _____

Home Address _____

Parent/Guardian Information:

Parent/Legal Guardian _____

Parent Phone: Home _____ Cell _____ Work _____

Employee Name (if different than parent/guardian) _____

Company Name _____ Work Location _____

May we contact your parent/guardian at: Home Cell WorkMay we leave a voice message at: Home Cell WorkMay we send you information at home: Yes NoMay we send you information via email: Yes No If yes, email: _____

Emergency Contact _____ Phone _____

Insurance Information: (Your insurance will ***not*** be billed for EAP sessions)Do you have health insurance: Yes No

Name of Parent/Guardian carrying insurance: _____

If yes, name of your insurance company: _____

Name of Insured Employee: _____

Referred by Home Mailing Website Bulletin Board/Poster Medical Doctor Family Initiated Training/Presentation Another Employee Other

**WAYNE CORPORATION
EMPLOYEE ASSISTANCE PROGRAM
CONFIDENTIALITY/STATEMENT OF UNDERSTANDING**

Fees and Cancellation Policy:

Services provided by Wayne Corporation are offered at no direct cost to clients. If assistance beyond the scope of services provided by Wayne Corporation is needed, the EAP counselor will help locate appropriate community resources. It is the client's responsibility to assume costs from such referrals.

PLEASE NOTE: Any missed appointment or cancellation with less than 24-hour notice is counted toward one of your free visits. _____ (please initial)

Feedback/Release of Information:

Self-referrals – If any employee or family member voluntarily comes in for assistance, no information concerning the person's counseling with Wayne Corporation will be discussed without the individual's written permission.

Permission:

Permission is hereby given to Wayne Corporation to render treatment and/or service to

(Child's/Adolescent's Name)

Confidentiality:

Wayne Corporation will keep all information gained through the counselor/client relationship strictly confidential, except as required by law or in situations deemed potentially life threatening.

Participation in the services offered by Wayne Corporation is voluntary. Wayne Corporation staff may follow-up by phone or letter for you to evaluate our effectiveness and your satisfaction.

Additional questions or comments can be directed to a Wayne Corporation counselor or staff person at 502-451-8262.

I have read this form and understand its content.

Name of Child/Adolescent

Signature of Parent/Guardian

Date

ALL INFORMATION IS CONFIDENTIAL

For each item below, please circle the number that most applies to your child/adolescent.

	Doesn't Apply	1	2	3	4	5 Very Serious
Problems with eating (overeate, binge or purge, etc)	0	1	2	3	4	5
School concentration difficulties	0	1	2	3	4	5
Grades dropping or consistently low	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Isolated socially from peers	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5
Bed Wetting	0	1	2	3	4	5
Soiling	0	1	2	3	4	5
Problems controlling temper	0	1	2	3	4	5
Problems with authority at school	0	1	2	3	4	5
Problems with authority at home	0	1	2	3	4	5
Anxiety/Nervousness	0	1	2	3	4	5
Lazy	0	1	2	3	4	5
Problems with marriage of parents/guardian	0	1	2	3	4	5
Problems with job of parents/guardian	0	1	2	3	4	5
Health Problems	0	1	2	3	4	5
Legal Situation (anyone in family)	0	1	2	3	4	5
Being abused (physically, emotionally, sexually)	0	1	2	3	4	5
Problems with family finances	0	1	2	3	4	5

Client Name _____

Please note any history of any serious injuries, surgeries, chronic illness or conditions:

Please list medications your child or teen is currently taking (including over the counter)

Has your child or adolescent used alcohol or other drugs? Yes _____ No _____ Don't Know _____

Has a friend or relative discussed concerns about your child's/adolescent's use of alcohol or drugs? Yes _____ No _____ Don't Know _____

Have you ever felt guilty about your own drinking or drug use? Yes _____ No _____

Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes _____ No _____

Are you a recovering alcoholic or recovering drug addict? Yes _____ No _____

Is there a history of problems with alcohol or drug use in your family? Yes _____ No _____