



# CLIENT DATA FORM

*\*Completed by client\**

Case #: \_\_\_\_\_

## CONFIDENTIAL

**NOTE:** The information on this form is presented only for use by First Advantage, EAP. Copying or distribution of this information for any other purpose violates laws regarding confidentiality.

Name: _____		<b>GENDER</b>		<b>EMERGENCY CONTACT</b>	
Address: _____		<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____	
				Telephone Number: _____	
<b>LIVING STATUS</b>		<b>AGE</b>		<b>EDUCATION COMPLETED</b>	
<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Co-habiting <input type="checkbox"/> Other _____		<input type="checkbox"/> Under 13 <input type="checkbox"/> 40-49 <input type="checkbox"/> 13-19 <input type="checkbox"/> 50-59 <input type="checkbox"/> 20-29 <input type="checkbox"/> 60-69 <input type="checkbox"/> 30-39 <input type="checkbox"/> over 69 Date of Birth: _____		<input type="checkbox"/> Elementary School <input type="checkbox"/> Some High School <input type="checkbox"/> HS Graduate or Equivalent <input type="checkbox"/> Trade or Vocation School <input type="checkbox"/> Completed 1-4 Yrs College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree	
				<b>INSURANCE</b> Please specify: _____ _____	
<b>ETHNICITY (Optional)</b>		<b>RELATIONSHIP TO EMPLOYEE</b>		<b>FOLLOW-UP</b>	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____ Please specify country of origin: _____		<input type="checkbox"/> Employee (self) <input type="checkbox"/> Spouse of Employee <input type="checkbox"/> Son/Daughter of Employee <input type="checkbox"/> Parent of Employee <input type="checkbox"/> Retired Employee <input type="checkbox"/> Spouse of Retired Employee <input type="checkbox"/> Other _____		Are you willing to allow us to follow-up with you to ask a few questions to determine if your needs were met through the service? <i>If yes, Can we follow-up with you by:</i> <input type="checkbox"/> Email _____ <i>(We will only email you ONE time with the survey. We will not use your email address for other purposes nor will we provide it to any other organization.)</i> <input type="checkbox"/> Phone _____ <input type="checkbox"/> No Follow-up <b>Thank you for helping us to ensure the delivery of quality services!</b>	
What do you hope to accomplish at the EAP? _____ How long has this been a concern? # _____ Years    # _____ Months    # _____ Weeks    # _____ Days Do you have any significant medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____ Who lives in the home with you? _____					
<b>FILL OUT THIS SECTION ONLY IF YOU ARE THE COVERED EMPLOYEE</b>					
<b>SALARY</b>		<b>JOB CATEGORY</b>		<b>JOB LEVEL</b>	
<input type="checkbox"/> Under \$20,000 <input type="checkbox"/> \$70,000 - \$99,999 <input type="checkbox"/> \$20,000 - \$29,999 <input type="checkbox"/> \$100,000 - \$149,999 <input type="checkbox"/> \$30,000 - \$39,999 <input type="checkbox"/> \$150,000 - \$199,999 <input type="checkbox"/> \$40,000 - \$49,999 <input type="checkbox"/> Over \$200,000 <input type="checkbox"/> \$50,000 - \$69,999		<input type="checkbox"/> Management <input type="checkbox"/> Operations/Labor <input type="checkbox"/> Technician <input type="checkbox"/> Marketing/Sales <input type="checkbox"/> Clerical/Office <input type="checkbox"/> Professional		<input type="checkbox"/> Executive/ Senior Management <input type="checkbox"/> Supervisory <input type="checkbox"/> Non-Supervisory – (receives overtime) <input type="checkbox"/> Non-Supervisory – (Exempt –no overtime)	
EMPLOYMENT: Length of employment with Company _____ years _____ months.    Company Name _____					
Please describe your employment position.					
Has a Manager/Supervisor discussed your work performance with you in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe discussions.					
Have you been involved in any on the job accidents in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe nature of accident.					
Do you have any problems with the following? Your Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No; Co-workers <input type="checkbox"/> Yes <input type="checkbox"/> No; The job itself <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes to any of the above, please describe.					