

PATHWAYS CASE OPENING DATA SHEET

NAME OF COUNSELOR: _____ **TODAY'S DATE:** _____

PLEASE COMPLETE THE FOLLOWING INFORMATION

EMPLOYER NAME: _____ **JOB TITLE** _____

PLEASE CHECK IF YOU ARE THE EMPLOYEE _____ **OR THE DEPENDENT OF THE EMPLOYEE** _____

NAME (FIRST) _____ **(MI)** _____ **(LAST)** _____

DATE OF BIRTH: _____ **AGE:** _____ **MARITAL STATUS:** _____ **GENDER:** _____

ADDRESS: _____ **CITY** _____ **STATE** _____ **ZIP** _____

Home Phone: _____ **Work Phone** _____

Cell Phone: _____ **Is there a number we should NOT call to contact you or leave a message? If so, please specify:** _____

E-Mail Address _____ *(Omit if you do not wish us to contact you via e-mail)*

PLEASE ANSWER THE FOLLOWING QUESTIONS. IF YOU ARE A DEPENDENT OF THE EMPLOYEE, ONLY ANSWER THE QUESTIONS WITH AN *

***HEALTH INSURANCE PLAN:** _____ **SS#** _____

***HIGHEST LEVEL OF EDUCATION:** _____ **YEARS WITH COMPANY** _____

***HOW WERE YOU REFERRED TO PATHWAYS EAP? (CIRCLE ALL THAT APPLY) SELF? SUPERVISOR? MEDICAL DEPT.?, OTHER? IF OTHER, PLEASE SPECIFY:** _____

***HAVE YOU BEEN TO EAP BEFORE? (Y/N)** _____ **IF YES, HOW MANY TIMES?** _____ **HAVE YOU HAD WORK PERFORMANCE PROBLEMS? (Y/N)** _____ **IF YES, PLEASE SPECIFY:** _____

IF YES, WERE ANY PERSONNEL ACTIONS TAKEN? PLEASE SPECIFY: _____

***PLEASE CIRCLE ANY OF THE FOLLOWING PERSONAL PROBLEMS: ALCOHOLISM, ALCOHOL RELATED (FAMILY MEMBER OR ACOA), OTHER DRUG ABUSE OR ADDICTION, DRUG RELATED (FAMILY MEMBER OR ACOA), EMOTIONAL, FAMILY, FINANCIAL, LEGAL, MARITAL, WORK RELATED, NO PERSONAL PROBLEM, OTHER (IF OTHER, PLEASE SPECIFY):** _____

HOW DID YOU BECOME AWARE OF EMPLOYEE ASSISTANCE PROGRAM? _____

ADDITIONAL COMMENTS IF NEEDED: _____

