VALLEY BAPTIST MEDICAL CENTER **EMPLOYEE ASSISTANCE PROGRAM**
Harlingen, Texas **VBMC 1960-002-0791**

READMISSION FOR SERVICE - ADULT

Please provide us with any changes in personal information that may have occurred since your last visit with EAP. By completing the following questions, as fully and as accurately as you can, you will facilitate your own therapy/counseling. It is understandable that you might be concerned about what happens to the information about you because much or all of the information is highly personal. Case records are strictly confidential and are protected as specified by law.

____
Name

____
Street Address (if different than that on file) City State Zip

_______________________ _________________________ __________________________
Cellular Phone Home Phone Business Phone/Pager

Please indicate where/how you would prefer to be contacted: __Cell __Home __Work __Email

If email, please indicate email address:___________________________________

Have there been any changes in those persons living with you? If so, who currently lives with you?

____

Person to notify in case of emergency: ____Same as that on file ___Other; If other provide information below:

____
Name Relationship

____
Street Address City State Zip

___________________ ____________________ ____________________
Cellular Phone Home Phone Business Phone

Email Address:____

OCCUPATIONAL STATUS

Please indicate any changes in employment since last admission:

____

Please indicate any additional Education or Special Training you received since last admission:

____

If you have changed employers , please provide the information requested below:

Current Employer: ____________________________________ Phone: ___________________________

Address: ____

Position/Department: ___________________________________ Start Date: _____________________

Job Satisfaction (check one): ____High ___Medium ___Low

Job Performance (check one): ____Above Satisfactory ___Satisfactory ____Below Satisfactory

MARITAL STATUS

Please indicate any changes in marital status:____

IF REMARRIED, please provide the following information:

____
Spouse's Name Spouse's Age Date of Marriage

____
Spouse's Occupation & Department Years of Education Highest Degree

Describe your relationship with your spouse: ____

____

If you have had any children born to you since last admission, please give their names and ages (if not living with you, indicate where they are residing). ____

Explain any custody issues: ____

CURRENT PROBLEM/SITUATION

Please indicate why you are requesting services and the type of difficulties you are experiencing.

____

____

When did your difficulties begin? ____

How serious do you consider your difficulties?____

MEDICAL HISTORY

Please indicate any changes in your health status and/or medical history, such as illnesses and/or a change in Primary Care Provider: ____

Indicate any and all medications and dosages that you are now taking.

Medication	Dose	Start Date	M.D. Prescribing

List all current illnesses/conditions.

Illness/Condition	Treating M.D.	Treatment

Please describe any changes in your use of tobacco, alcohol or other chemical substances: ________________
____

In order to obtain a full and complete picture of all the things that may be of concern to you, please complete the following checklist.

CHECK any of the boxes of the following concerns that apply to you and rate its severity in the blank at the right, using the following scale:

1 = Mildly distressing
2 = Moderate
3 = Serious
4 = Severe
5 = Very severely distressing

Example: [3] Marital Stress 3

θ Marital Stress___
θ Other Family Problems___
θ Other Relationship Problems___
θ Problems at work/school___
θ Health Problems___
θ Financial Problems___
θ Legal Problems___
θ Sad/Depressed__
θ Loss of Appetite___
θ Loss of Weight___
θ Gain of Weight___
θ Difficulty sleeping__
θ Difficulty concentrating___
θ Quick Change of Moods___
θ Dwelling on Problems___
θ Problems with Breathing____
θ Problems Controlling My Anger or Urges___
θ Problems Controlling My Thoughts ___

θ Feeling suicidal___
θ Feeling worthless___
θ Lack of interest/enjoyment___
θ Too Many Drugs___
θ Too Much Alcohol___
θ Feel Negative About Future___
θ Hard to Make Friends___
θ Feeling Lonely___
θ Sexual Problems___
θ Less Energy than Usual___
θ More Energy than Usual___
θ Very Talkative___
θ Restless/Can't Sit Still___
θ Nervous/Tense___
θ Panicky___
θ Shaky/Trembly___
θ Feeling Others Are Out to Get Me___
θ Other_______________

θ Upset Stomach______
θ Sweating ______
θ Lightheaded/Dizzy______
θ Too Much Worry______
θ Too Many Fears______
θ Feeling Guilty______
θ Feeling Angry/Frustrated______
θ Nightmares______
θ Feel Ignored/Abandoned______
θ Too Much Pain ______
θ Confused______
θ Laugh without Reason ______
θ Memory Problems______
θ See/Hear Strange Things______
θ Hard to Trust Anyone ______
θ Hot or Cold Spells ____
θ Watched/Talked About By Others______
θ Other________________

List any other comments or ideas you have that may be helpful to the course of your therapy:

____

____

____

_____________________________________ _____________________________
Signature Date

CONSENT TO RECEIVE SERVICES

This will acknowledge and certify that on the date noted below, I requested Employee Assistance Program services. I understand that a treatment program plan will be implemented to meet the goals which have been jointly developed by myself and my counselor/therapist.

I further understand that my records are confidential and are protected by law. In most cases, they may not be released without my prior written consent. I have been apprised that there are some limited exceptions to confidentiality including, but not limited to when (a) a life-threatening situation exists (suicide or homicide); (b) there is a strong suspicion of child abuse occurring in the home; (c) I am involved in a criminal proceeding as a defendant, victim or witness.

I further acknowledge that in order for me to achieve the treatment goals that I have chosen for myself, it will be my responsibility to actively participate in and cooperate with the treatment process. If I am not in agreement with any aspect of the process, I will bring it to the attention of my counselor/therapist. I understand that I am free to withdraw from treatment at any time.

__________________ _________________________________
Date Signature of Client/Parent/Legal Guardian

__________________ _________________________________
Date Signature of Witness

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