OUTCOMES INC.
BUILDING PATHWAYS TO WELLNESS
COUNSELING · EMPLOYEE ASSISTANCE · CONFLICT RESOLUTION

Client Face Sheet

Client Account # _____

FOR OFFICE USE ONLY:

☐ CAP-EAP ☐ Insurance ☐ Self-pay ☐ NONCAP-EAP ☐ Relative/Significant Other

Information

Client Name:	**DOB**:	**SSN:**	**Age**:
Address:	**City**:	**ST**:	**Zip**:
Home Phone#: **Messages Ok?** ☐ Yes ☐ No	**Work Phone#**: **Messages Ok?** ☐ Yes ☐ No	**Mobile Phone#**: **Messages Ok?** ☐ Yes ☐ No	
Employer:	**Occupation**:	**Hire Date**:	
Gender: ☐ Male ☐ Female	**Language**: ☐ English ☐ Spanish ☐ Both ☐ Other: _____		

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

Ethnicity (optional): ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other:_____

Education Completed: ☐ Grades 1-12 ☐ High School or Equivalent ☐ College 1-4 years ☐ College Graduate ☐ Graduate School

How would you like to receive reminder calls

Text _____ **Voice** _____ **Email** _____

For EAP Employees Only

Relationship to Client: ☐ Self ☐ Parent ☐ Spouse/Partner ☐ Other:_____

Referred By: ☐ Self ☐ Co-worker ☐ Supervisor Mandated ☐ Family Member ☐ Supervisor Recommended

How did you hear about EAP Program? ☐ Brochure/Poster/Literature ☐ Co-worker ☐ Employee Orientation ☐ Other: _____

Status: ☐ Salaried ☐ Hourly ☐ Commissioned **Hire Date**:

Job Category: ☐ Administration/Management ☐ Sales/Marketing ☐ Operations/Maintenance ☐ Professional/Technical ☐ Clerical/Support ☐ Labor/Manufacturing ☐ Other: _____

Identify work performance problems (mark at least one): ☐ Absenteeism/Tardiness ☐ Safety/Security ☐ Positive Alcohol/Drug Test ☐ Quantity/Quality of Work ☐ N/A-Other Family Member ☐ No Work Performance Problem

For Insurance and EAP Clients Only

Insurance or EAP Company name: _____ Policy #_____

Insurance company contact phone # _____ Group # _____

Insurance and EAP Clients Only

By signing below, I am authorizing OUTCOMES, INC. to release any information and benefits necessary to process my insurance claim and/or EAP invoice for services provided by OUTCOMES, INC. and authorize direct payment to OUTCOMES, INC.

Client's Signature:_____ **Date**: _____