Client Intake Form

Date:
Client:
Company Name/Company Location (City & State):
Clinician Name & Phone Number:
Clinician Address:

Job Category:

☐ Hourly
☐ Management
☐ Professional
☐ Family Member

Problem Category: Check all that apply and ***circle*** the primary problem.

☐ Bereavement
☐ Chemical Dependency
☐ Chemical Dependency Family
☐ Depression
☐ Eating Disorder
☐ Family/Children
☐ Family/Marital
☐ Medical Issues
☐ Psychiatric
☐ Medical Issues
☐ Relationship Issues
☐ Stress Anxiety
☐ Work/Interpersonal
☐ Work/Overload

- [ ] Gambling
- [ ] Work/Performance
- [ ] Work/Career

Disposition:

- [ ] EAP only
- [ ] Day Treatment
- [ ] Inpatient
- [ ] Outpatient
- [ ] Self Help
- [ ] Referral Declined
- [ ] Other:

Effect problem has on work:

- [ ] Great Effect
- [ ] Moderate Effect
- [ ] Slight Effect
- [ ] No affect
- [ ] Not applicable

Form can either be mailed to Comprehensive EAP, 4 Mount Royal Ave, STE 310, Marlborough, MA 01752, faxed to 774-463-3455 or emailed to jsagor@compeap.com