



Client Intake Form

Client Name:	Intake Date:
Client's Company Name:	
Client's Company Location (City & State):	
Clinician Name:	Clinician Phone:
Clinician Mailing Address:	

Job Category:

- Hourly
- Management
- Professional
- Family Member
- Unknown

Effect problem has on work:

- Great Effect
- Moderate Effect
- Slight Effect
- No Effect
- Not Applicable

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

- | | |
|---|--|
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Medical Issues |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency Family | <input type="checkbox"/> Medical Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Stress Anxiety |
| <input type="checkbox"/> Family/Children | <input type="checkbox"/> Work/Interpersonal |
| <input type="checkbox"/> Family/Marital | <input type="checkbox"/> Work/Overload |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Work/Performance |
| | <input type="checkbox"/> Work/Career |

Disposition:

- | | |
|---|------------------------------------|
| <input type="checkbox"/> EAP only | <input type="checkbox"/> Self Help |
| <input type="checkbox"/> Day Treatment/Intensive Outpatient | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Referral Declined | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Inpatient | |
| <input type="checkbox"/> Outpatient (Either through insurance or private pay) | |

Please comment below on any *notable* client presentation matters (e.g. late to session(s); remarkable appearance issues; aggressive behaviors; disorientation; etc.):