

Quinn & Associates EAP Intake / Follow-up Form

Please Fill Out Completely

Client's Company _____ Appointment Date _____

Site Seen At _____ Counselor _____

Name _____ SS# _____
Last First MI Nick name

ADDRESS _____ HOME PHONE () _____

CITY _____ STATE _____ ZIP _____ WORK PHONE () _____

DOB _____ AGE _____ CLIENT# _____ CO CITY/STATE _____

MALE / FEMALE SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOW (ED)

CO DEPT _____ JOB TITLE _____ WORK HRS _____ YRS of SVC _____

Referred by SELF / SU^PV / FAM / OTHER EMPLOYEE / DEPENDENT / FAMILY UNIT

SUPERVISOR _____ PHONE () _____

INSURANCE _____ GRP# _____ PHONE () _____

ASSESSMENT PROBLEMS

Please indicate "1" for primary problem and "2" and above for secondary problems.

___ Abuse (AB)	___ Job Performance (JP)	CHEMICAL DEPENDENCY
___ Bereavement (BE)	___ Job Stress (JS)	___ Alcohol (AL)
___ CoDependency (CO)	___ Legal (LE)	___ Drug (DR) Specify _____
___ Denies Problem (DP)	___ Marital (MA)	___ A/D (AD) Specify _____
___ Family (FA)	___ Other (OT)	___ Family (FC) Specify _____
___ Financial (FI)	___ Physical Health	
___ Gambling	___ Post Trauma (PT)	
	___ Psychological (PS)	

REFERRAL

Please indicate "1" for primary problem and "2" and above for secondary problems.

Inpatient: ___ Psychological (IPS) ___ Chemical (ICH)

Outpatient:

___ Abuse (AB)	___ Family (OFA)	___ Physical (OPH)
___ Bereavement (OBE)	___ Financial (OFI)	___ Psychological (OPS)
___ Chemical (OCH)	___ Legal (OLE)	___ Refused Referral (RFR)
___ CoDependency (OCO)	___ Marital (OMA)	___ Self Help Group (SHG)
___ EAP only (EAP)	___ Other (OOT)	

REFERRAL NAME _____ PHONE () _____

ADDRESS _____

NOTES

FOLLOW-UP

DATE _____ FOLLOWING REC. Y/N NOTES _____
(please use other side for comments/recommendations)

