

**EMPLOYEE ASSISTANCE PROGRAM
CLIENT INTAKE INFORMATION**

WORK INFORMATION

1. Name _____

Employer: _____

Job Title: _____
2. Length of Employment: _____ Job Status:
Full Time () Part Time () Retired ()
3. Were you referred to EAP by your Supervisor? Yes () No ()
4. If yes, name of Supervisor: _____

Phone #: _____
5. Have you received disciplinary action/probation/suspension: Yes () No ()
6. During the past 30 days: Number of job accidents: _____
a. Number of sick days used: _____
b. Number of times tardy or left early (unplanned): _____

Explain: _____
7. Does your employer provide this EAP service for you or are you coming under your spouses, parents or other family members plan? _____
8. If you are not the employee what company is providing this service for you?

9. New to EAP? Yes () No () If no, When?: _____