

Frank Horton Associates, LLC  
Employee Assistance Program  
1-800-326-3864/Fax 919-850-9825

CLIENT INTAKE & ASSESSMENT FORM

Date Called \_\_\_\_\_

Type of Referral S \_\_\_ I \_\_\_ F \_\_\_ Supervisor \_\_\_\_\_

Client Name: \_\_\_\_\_ Company: \_\_\_\_\_

Client Issue: \_\_\_\_\_

Assigned Counselor: \_\_\_\_\_ Appointment Date & Time: \_\_\_\_\_

Session Location: \_\_\_\_\_

Presenting Issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mental Status: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family Composition/Social Support : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical/Psychiatric History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

