MERCY EMPLOYEE ASSISTANCE PROGRAM- Intake Assessment Form

Client Name: ____ Date: ___________

S. **Subjective-**Presenting Problem:

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O. **Objective-** Including CD Assessment, Lethality Risk, History and Family History:

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A. **Assessment:** ____

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P. **Plan:** ____

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Goals:	Action Plan:
1.___________________________________	____
2.___________________________________	____
3.___________________________________	____

Client Strengths:____

Referral Sources:	Accepted?
1.____	☐ Yes ☐ No
2.____	☐ Yes ☐ No

Problem Category:

- ☐ Chemical Dependency
- ☐ Critical Psychiatric
- ☐ Non-Critical Psychiatric
- ☐ Marital Relationship
- ☐ Financial
- ☐ Family Chemical Dependency
- ☐ Social/ Family
- ☐ Medical

Clinician: (print) ____

Clinician Signature/Credentials: ____