

KGA, Inc.

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EAP Intake Form

Client Name:	Date of Intake:
Client Company:	KGA Case Manager:
Home Phone:	Referral Source:
Work Phone:	Age:
Cell Phone:	Sex:
Company Location:	Insurance:
Client is:	SS#:

Affiliate Please Complete:

Primary Presenting Issue: _____

Total # of Sessions: _____ Dates of Sessions: _____

Clinical Summary: _____

Follow up: How is client doing after referral? _____

Is problem interfering with work? If yes, how? _____

If you are referring this client to yourself for longer-term treatment you must also offer at least one other option, preferably two.

Referrals/Resources: _____

Referrals/Resources Phone: _____

Affiliate Name: _____ Phone: _____

Affiliate Signature: _____ Date: _____