

U.S. Steel Tower  
 8th Floor  
 600 Grant Street  
 Pittsburgh, PA 15219  
 412-647-3698 or 1-800-647-3327  
 412-647-9484 Fax

|                            |                    |
|----------------------------|--------------------|
| Date: _____                | Case Number: _____ |
| Counselor: _____           |                    |
| Counselor's Phone #: _____ |                    |

Client First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Employee's First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_ Name of Insurance: \_\_\_\_\_

**Ethnic Background:**

- Caucasian     African American     Hispanic  
 Native American     Asian     Biracial     Other

**Appointment offered (check one)**

- Routine — within 5 business days  
 Urgent — within 2 business days  
 Emergent — same day

**To be completed by the counselor:**

**Please complete all five sections prior to faxing form.**

**1** NOTE: Only mark 1 once and 2 once  
**Indicate (1) for primary presenting problem**  
**Indicate (2) for secondary present problem**

**Abuse/Addiction of Client**

- Alcohol Abuse  
 Drug Abuse  
 Gambling  
 Internet  
 Sexual  
 Abuse Other

**Family**

- Family Conflict  
 Child  
 Teen  
 Parent/Child Relationship  
 Domestic Violence  
 Reaction to Illness  
 Living w/Abuse or Addiction  
 Living w/Emotional Problem  
 Elder Care  
 Family Other

**Marital/Relationship**

- Marital/Relationship

**Emotional Problems**

- Depression  
 Anxiety  
 Grief  
 Emotional Other

**Trauma and Abuse**

- Physical Abuse  
 Sexual Abuse  
 Emotional Abuse  
 Post Traumatic Stress  
 Trauma Other

**Work Related**

- Relationship w/Co-workers  
 Relationship w/Supervisor  
 Workplace Violence  
 Harassment  
 Job Performance  
 Work Stress  
 Work Related Other

**Medical Condition**

- Medical Condition

**Financial**

- Financial Planning  
 Debt  
 Financial Other

**Legal**

- Legal

**Other**

- Eating Disorder  
 Stress  
 Career Concerns

Statement of Understanding  
 signed? \_\_\_\_\_

**2** How is this affecting employee's job?  
 (Check all that apply.)

- Absent  
 Tardy  
 Safety Violations  
 Problems Relating to Other Employees  
 Quality/Quantity of Work Decreased  
 Workers' Comp Case  
 Alcohol/Drugs Suspected on the Job  
 Theft  
 Other  
 N/A Family Member  
 No Problems

**3** Workdays missed in the past 12 months  
 due to presenting problem:

- 0     1-5     6-10     11-15     16+

**4** Chemical Dependency Screen:

- Yes     No     No Indicator

**5** Lethality Risk:

- Yes     No     No Indicator

If yes, staffed with care manager: \_\_\_\_\_

Yes  Intake Date: \_\_\_\_\_

No

**This form must be submitted within 72 hours of initial session. Fax it to 412-647-9484.**