

**MAZZITTI & SULLIVAN**  
**EVALUATION INITIAL REPORT FORM**

Date: \_\_\_\_\_ Counselor: \_\_\_\_\_ Diag. Code: \_\_\_\_\_

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Client Name: \_\_\_\_\_ Home #: \_\_\_\_\_

Address: \_\_\_\_\_ S.S. #: \_\_\_\_\_

\_\_\_\_\_ Marital Status: \_\_\_\_\_

Sex: Male  Female  D.O.B.: \_\_\_\_\_

Client Type: Employee  Family Member

Client Referred By: Self  Family  HR/Supervisor  Mandated

Health Insurance Co.: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

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**EAP COMPANY EMPLOYEE INFORMATION**

Name of Employee: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Job Classification: \_\_\_\_\_ Length of Service: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_

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**COUNSELOR'S USE ONLY BELOW THIS LINE!**

**PRIMARY PROBLEM TYPE (CHECK ONLY ONE PLEASE)**

Emotional/Personal:  Family/Marital:  D/A:  Vocational:  Health Related:

Other (Specify): \_\_\_\_\_

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**This form must be completed at the initial evaluation/assessment and sent to the EAP.**

3207 N. Front Street, Harrisburg, PA 17110 \* 1-800-241-5740 \* Fax: 717-901-5659