Connecticut Behavioral Health Associates, P. C.

CLIENT INTAKE FORM

Client Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Social Security #: _____ - _____ - _____ ☐ Male ☐ Female

REQUESTED SERVICES ☐ Medication Management ☐ Therapy ☐ Substance Abuse Treatment ☐ TMS

PREFERRED LOCATIONS ☐ New London ☐ Norwich ☐ Pawcatuck ☐ Groton ☐ Plainfield
☐ Old Saybrook ☐ Hamden ☐ Southington ☐ New Britain ☐ Glastonbury

Reason for Treatment or Current Symptoms: _____

_____

_____

Current Medications & Prescribing Doctors: _____

_____

_____

PRIMARY INSURANCE INFORMATION

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's SSN #:_____ - _____ - _____ Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins Company Name: _____ Effective Date: _____

ID#: _____ Group #: _____ Ins Company Phone: _____

SECONDARY INSURANCE INFORMATION

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's SSN #:_____ - _____ - _____ Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins Company Name: _____ Effective Date: _____

ID#: _____ Group #: _____ Ins Company Phone: _____

Referred By: _____ **Date:** _____

******Please fax completed form to our Intake Department at (860) 437-6920******