Community Health Connections
We take great care of you!

Behavioral Health Intake Screening Form

Name: _____ DOB: _____ Soc. Security Number: _____

Address: _____

Town/City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Email address: _____

Are you here for: (check all that apply)

□ Counseling –or- □ Suboxone Screening -or- □ Substance Abuse Counseling

Have you ever been seen in this department before? □ Yes □ No

Do you have a family member that works for CHC? □ Yes □ No

Who? _____

Are you receiving therapy or psychiatric services anywhere else? □ Yes □ No

Where? _____ For what? _____

Do you suffer from any of the following?

□ Depression □ Relationship Problems
□ Anxiety □ Substance Use
□ Bipolar Disorder □ Schizophrenia
□ Loss/Grieving □ Other (please specify): _____

Prefer to see a □ Male or □ Female Counselor –or- □ it does not matter

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If you are a minor (under 18 years old), who has legal custody of you?

□ Mom □ Dad □ Both □ DCF □ Guardian

Name: _____ Name: _____ Relationship: _____

Emergency Contact

Name: _____ Relationship: _____

Street Address: _____ Town/City: _____

Home Phone: _____ Cell Phone: _____

I hereby authorize Community Health Connections, Inc. to communicate my health information with the Emergency Contact listed above: Signature: _____ Date: _____

Anything else you would like us to know:

For office use only:

PCP_____ Insurance _____