CROSSROADS Behavioral Health

10 North Main Street ● West Hartford CT 06107 ● Tel: 860-233-8111 ● Fax: 860-236-2016

Coaching Intake Form

Welcome to my office. While you are waiting, I would appreciate your completing this form. The information you are providing will be important in getting to know you.

Name:_____ Date of Birth:_____ Age:_____

Address:_____
(Street) (City) (Zip)

Phone: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

E-Mail Address:_____ Marital Status:_____

Referred by:_____

BACKGROUND INFORMATION

High School:_____ Graduation Date:_____

College:_____ Starting Date:_____

Major:_____ Ending Date:_____

Advanced Degree:_____ School:_____

EMPLOYMENT

Company Name:_____

Position:_____ Start Date:_____

Please Initial and Sign:

_____ I understand that I will be charged for appointments that are canceled less than 24 hours in advance and for ***No Show*** appointments. **Cancellations must be made by telephone only.**

_____ I understand that payment (in full) is expected on the day of my appointment.

_____ _____
(Signature) (Date)