



SACRED HEART NAVIGATIONS

New Client Intake & Screening Form

Please complete this brief form to help determine whether the services offered are appropriate for your current needs. **Basic contact information and the Current Well-Being & Safety section are required.** All other questions are optional and are intended to help me better understand how I may support you. If you prefer not to answer an optional question in writing, please feel free to discuss it with me directly.

Basic Information

Name: _____

Preferred name: _____

Date of birth: _____

Phone: _____

Email: _____

Preferred method of contact: ☐ Phone ☐ Text ☐ Email

Emergency contact: _____

Relationship: _____

Emergency contact phone: _____

What Brings You Here?

What would you most like support with at this time?

What would you hope to gain from our work together?

Current & Previous Support

Are you currently receiving care from any of the following?

☐ Therapist/Counselor ☐ Psychiatrist ☐ Primary care/medical provider ☐ Other helping professional ☐ None

Have you previously received mental health counseling, psychiatric care, or treatment that you believe would be important for me to know about? ☐ No ☐ Yes

If yes, please briefly explain:

Have you ever been given a mental health or psychiatric diagnosis by a qualified healthcare professional? ☐ No ☐ Yes

If yes, please list any diagnoses you believe are relevant:

Are you currently taking prescription medications that may be relevant to your emotional or psychological well-being? ☐ No ☐ Yes

If yes, please list:

Current Well-Being & Safety

Within the recent past, have you experienced any of the following? *Please check all that apply.*

- ☐ Thoughts of suicide or not wanting to be alive
- ☐ Self-harm or thoughts of harming yourself
- ☐ Thoughts of seriously harming another person
- ☐ Feeling unsafe in a relationship or living situation
- ☐ Hearing or seeing things others do not appear to experience
- ☐ Periods of unusually elevated energy, very little need for sleep, or significantly impulsive behavior
- ☐ Severe difficulty functioning or caring for yourself
- ☐ Recent psychiatric hospitalization or mental health crisis
- ☐ None of the above

If you checked any of the above, please briefly explain or indicate that you would prefer to discuss this privately:

Alcohol & Other Substances

Is your current or recent use of alcohol, cannabis, psychedelics, prescription medications, or other substances something you believe may be affecting your well-being?

☐ No ☐ Yes ☐ Unsure ☐ Prefer to discuss privately

If yes or unsure, please briefly explain:

About You

Are there any important personal, family, relationship, cultural, spiritual, neurodivergent, medical, grief/loss, or life circumstances you would like me to understand?

What currently helps you cope or feel supported?

Is there anything that would help you feel more comfortable or supported during our work together?

Understanding of Services

I understand that the services being considered are non-clinical and non-medical psycho-spiritual counseling services and are not a substitute for licensed psychotherapy, psychiatric care, medical treatment, diagnosis, or emergency/crisis services.

☐ I understand

PRACTITIONER USE ONLY

Initial disposition:

- ☐ Appropriate for services
- ☐ Appropriate with concurrent professional care
- ☐ Additional consultation/screening needed
- ☐ Referral recommended
- ☐ Immediate safety/crisis response required

Relevant considerations / follow-up:

Referrals or actions taken, if applicable:

Practitioner initials: _____ Date: _____