

# Life Navigation, LLC

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## Client Intake Form

Instructions: Please fill out this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. If certain questions do not apply, leave them blank.

Information supplied by: \_\_\_\_\_ Relationship to client: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Gender: \_\_\_M \_\_\_F

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in school: \_\_\_\_\_

Address: \_\_\_\_\_

May I mail information to the above address? \_\_\_Y \_\_\_N

Email Address: \_\_\_\_\_ May I email information to you? \_\_\_Y \_\_\_N

Are you interested in received a quarterly newsletter via email? \_\_\_Y \_\_\_N

What phone number is the best to reach you? \_\_\_\_\_ (c) or \_\_\_\_\_ (h)

How should we identify ourselves? \_\_\_\_\_

In the unlikely event of an emergency and you are unreachable, please list an alternative contact and their appropriate contact information: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

Are you currently working? \_\_\_Y \_\_\_N If yes what is your occupation? \_\_\_\_\_

How long have you been working there? \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any significant health conditions:

Please list medication and dosage you may be taking:

With whom do you currently live with? \_\_\_\_\_

Are you \_\_\_Married/Cohabitation \_\_\_Single \_\_\_Divorced \_\_\_Widow

How many children do you have? \_\_\_\_\_

Names and Ages: \_\_\_\_\_

With whom do the children live with? \_\_\_\_\_

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

- Anger Management       Anxiety       Coping       Depression  
 Eating Disorder       Fear/phobias       Mental Confusion       Sexual Concerns  
 Sleeping Problems       Addictive Behaviors       Alcohol/Drugs       Hyperactivity

Other mental health concerns (specify): \_\_\_\_\_

How long has this problem persisted? \_\_\_\_\_

Under what conditions do the problems usually get worse? \_\_\_\_\_

Under what conditions do the problems usually get better? \_\_\_\_\_

Have you ever attempted to commit suicide or seriously harm yourself? \_\_\_\_\_

Have you ever attempted to kill or seriously harm someone else? \_\_\_\_\_

Have you ever hit, slapped or choked any of your loved ones? \_\_\_\_\_

Have you ever been the victim of physical, sexual or verbal abuse? \_\_\_\_\_

Have you been involved in previous counseling?  YES  NO

	YES	NO	When	Where	Reaction or overall experience
Counseling/Psychiatric	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____

Have you ever been involved in any support groups? \_\_\_\_\_

Does anyone in your family have a history of emotional problems? \_\_\_\_\_

### Current Substance Usage

	First age	Current Amount	Method of use	Last use
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Opiates	_____	_____	_____	_____
Ecstasy	_____	_____	_____	_____
PCP	_____	_____	_____	_____
Other	_____	_____	_____	_____

Have you ever had issues with gambling? \_\_\_\_\_

Has anyone in your family had issues with substance abuse or gambling? \_\_\_\_\_

Brief legal history? \_\_\_\_\_

Currently on probation/parole? \_\_\_\_\_

Open court cases? \_\_\_\_\_

Anything other information that you'd like me to be aware of? \_\_\_\_\_