David E. Briggs, LCPC
6645 N. Oliphant Avenue, Suite F
Chicago, IL 60631
P: 847.858.7277 FAX: 855.787.3065
david@briggstherapy.com

CLIENT INTAKE INFORMATION

Name: _____

Address:_____

City: _____ State: _____ Zip:_____

Preferred Phone: _____ ❒ Cell ❒ Home ❒ Work

Can I leave a message? ❒ Yes ❒ No Gender : ❒ Male ❒ Female

Email: _____

Date of Birth: _____ Social Security Number: _____

Check one: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Domestic Partnership ❒ Widowed

Employment Status: ❒ Full-time ❒ Part-time ❒ Unemployed ❒ Retired ❒ Disabled ❒ Student

Children and Ages: _____

Emergency Contact Information:

Name: _____ Relationship to Client:_____

Address: _____Phone: _____

Insurance Information:

Insurance Company: _____

Address:_____ Phone:_____

Insured's Name: _____Insured's SSN:_____ Birthdate: _____

Group #: _____ Policy/Member#:_____

Name of Employer: _____

Address: _____Phone: _____

History:

Have you ever been in therapy previously? ❒ Yes ❒ No When? _____

Reasons for ending therapy:_____

What medications do you take on a regular basis? _____

Who is prescribing the medication? ❒ Psychiatrist ❒ Physician ❒ Other:_____

How long have you been taking the medication?_____

How is your physical health at present? ❒ Poor ❒ Satisfactory ❒ Good ❒ Very Good

Please list any persistent physical symptoms or health concerns *(e.g. chronic pain, headaches, hypertension, diabetes, etc.)* _____

Are you having problems sleeping? ❒ Yes ❒ No If yes, please check all that apply:

❒ Sleeping too little ❒ Sleeping too much ❒ Poor Quality Sleep ❒ Disturbing Dreams ❒ Other

How many times per week do you exercise? _____ Approximately how long each time?_____

Do you regularly use alcohol? ❒ Yes ❒ No If yes, how often? _____

Do you engage in recreational drug use? ❒ Yes ❒ No If yes, how often? _____

Have you had suicidal thoughts recently? ❒ Frequently ❒ Sometimes ❒ Rarely ❒ Never

Have you had suicidal thoughts in the past? ❒ Frequently ❒ Sometimes ❒ Rarely ❒ Never

Are you currently in a romantic relationship? ❒ Yes ❒ No If yes, how long?_____

On a scale of 1-10, how would you rate the quality of your relationship?_____

In the past year, have you experienced any significant life stressors?

_____

Have you ever experienced:

Extreme depressed mood: ❒ Yes ❒ No
Phobias: ❒ Yes ❒ No
Hallucinations: ❒ Yes ❒ No
Eating Disorder: ❒ Yes ❒ No
Obsessions/Compulsions: ❒ Yes ❒ No
Alcohol/Substance Abuse: ❒ Yes ❒ No
Mood Swings: ❒ Yes ❒ No
Extreme Anxiety: ❒ Yes ❒ No
Panic Attacks: ❒ Yes ❒ No
Body Image Problems: ❒ Yes ❒ No
Homicidal/Suicidal thoughts: ❒ Yes ❒ No

Family Mental Health History

Has anyone in your family experienced difficulties with the following? Check all that apply and please indicate your relationship to that family member.

❒ Depression _____ ❒ Anxiety Disorders_____
❒ Schizophrenia _____ ❒ Eating Disorders _____
❒ Alcohol/Substance Abuse _____ _ ❒ Bipolar Disorder_____
❒ Trauma History _____ ❒ Suicide Attempts_____

Please briefly describe your current situation and what led you to seek counseling/ therapy:

Client Signature _____ Date _____