COUNSELING INTAKE Date:

Jana Briggs Counseling, LLC - Sharon DeGuevara Counseling, LLC - Ashley Williamson Counseling, LLC - Hannah Kautz Counseling, LLC

General Information

Name: ____ Date of Birth:______________________

Home Address: ____ City/State/Zip: __________________________

Home Phone: ____ Work Phone: __________________________

Cell Phone: ____ Email: __________________________

May I call and leave messages at home? □ Yes □ No Work? □ Yes □ No Cell Phone? □ Yes □ No
May I send mail to your home address? □ Yes □ No

Marital Status: □ S □ M □ D □ W No. of Marriages: ________________ Date of Current Divorce/Sep. __________________

Occupation: ____ Highest Level of Education: ______________

Children(s) Name(s): ____ DOB: _______________ □ M □ F

____ DOB: _______________ □ M □ F

____ DOB: _______________ □ M □ F

Counseling and Medical History

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? Do you have chronic medical conditions or learning disabilities? If yes, please list: ____

____

Daily Medication(s) Over the Counter or Prescription	Prescribing Physician

Family Physician: ____ Phone: ____________________________

Have you had previous counseling? If yes, for how long? ________________________________ For what reason? _____________

____

Has anyone in your family ever been treated for or diagnosed with any type of mental illness (depression, anxiety, etc)? If yes, please

explain. ____

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Jana Briggs, M.A., NCC, LPC *Contact (303)495-0317* *FAX (303) 993-4770*
www.JanaBriggs.com *info@janabriggs.com*

Reasons for Seeking Help

What concerns have brought you to counseling today? ____

____

When did these concerns begin to be a problem for you? ____

What concerns about you have been identified by others? ____

Please indicate which of the following are currently problems for you:

- □ Feeling inferior to others
- □ Under too much pressure and feeling stressed
- □ Excessive down or unhappy/depressed mood
- □ Excessive anxiety or worry
- □ Feeling lonely
- □ Feeling paranoid
- □ Crying Spells
- □ Obsessions/Compulsions
- □ Concerns about finances
- □ Feeling "numb" or cut off from others
- □ Not being able to say what you really think or feel
- □ Angry outbursts
- □ Excessive fear of specific places or objects
- □ Difficulty making friends/difficulty keeping friends
- □ Eating too little/too much/bingeing and purging
- □ Feeling as if you'd be better off dead
- □ Feeling out of control or manipulated by others
- □ Difficulty making decisions
- □ Loss of interest in sexual relationships
- □ Other: ____

What do you hope to accomplish in counseling? ____

____

____

Emergency Contact* – Name: ______________________________________ **Phone:** ___________________________

Relationship to You: ____

This person will only be contacted in the case of a counseling related emergency – please discuss any questions or concerns you have about this with me.