Peace of Mind Counseling, LLC

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Career Intake Form

Thank you for taking the time to complete this form. The information and history you provide to me will help me better understand you and will be helpful in planning services for you. Please answer the questions carefully and ask about any question you do not understand. The information on this form is subject to client-therapist confidentiality.

Date: _____

Full Name: _____ Date of Birth: _____

Have you previously attended therapy or invested in professional career development services before? **Y or N**

Who did you see? _____

Reason you sought services: _____

Type of counseling you received: _____

Was the therapy/services helpful? (Circle one) **Helpful Somewhat Helpful Not Helpful**

Education/Training Information

What is your highest education level completed? _____

Current School (if applicable): _____

What is the highest grade or degree that your parents or guardians completed? _____

Please list any other relevant education, certifications, or specialized training you have:

_____

_____

Are you, or would you like to, pursue further education? If so, please describe what you are thinking about and why: _____

_____

_____

What subjects have you **MOST** enjoyed studying? _____

_____

What subjects have you **LEAST** enjoyed studying? _____

_____

Are you experiencing any difficulties/stressors at school or related to your education? **Y or N**

If yes, please briefly describe:_____

_____

_____

Employment Information

What is your current employment status? (Check all that apply)

___Employed Full Time
___Employed Part Time
___Homemaker
___Unemployed
___Seeking Employment
___Volunteer
___Student
___Disabled
___Military
___Retired
___Other, please describe:
_____

Current job title and employer: _____

How long have you been in your current position? _____

On a scale of 1 to 10, with 1 being "Least Satisfied" and 10 being "Most Satisfied," how satisfied are you with your current career/job? _____

Are you experiencing any difficulties/stressors in your current job? **Y or N**

If yes, please briefly describe:_____

_____

_____

Career Information

In your words, please describe what prompted you to seek career counseling at this time:

_____

_____

_____

_____

What do you hope to accomplish by engaging in career counseling?

_____

_____

_____

What would you **MOST** like to change about your current career/job? _____

_____

_____

What are your current career goals? (Even if you are uncertain, just fill in any thoughts that you might have): _____

_____

_____

If you could do/be anything you want, what would it be? _____

_____

What kinds of barriers have/could get in the way of meeting your career goals? _____

_____

Please number in order from 1 to 5 (with 1 being most important) which five values are most important for you to receive from work?

___Achievement
___Authority
___Challenge/adventure
___Competition
___Creativity
___Environment
___Free time/leisure
___Helping others/society
___Independence/Self-Direction
___Intellectual Stimulation
___Leadership
___Money
___Moral Fulfillment
___Security
___Stability
___Status/recognition
___Variety

Thinking back over your life, what aspects of your prior experience have you **MOST** enjoyed?

_____

_____

Thinking back over your life, what aspects of your prior experience have you **LEAST** enjoyed?

_____

_____

Skills

What are the **top three** skills that you offer an employer?

1. _____

2. _____

3. _____

What can you do **easily** that other people find difficult? _____

_____

_____

What is **difficult** for you that others seem to find easier? _____

_____

_____

What are the skill requirements for your dream job? (Even if you are unsure, list what you think they might be): _____

_____

_____

Family Background

If known, what were your parents'/guardians' career(s)? _____

_____

Did they like their career(s)/were they satisfied with their work? _____

What types of careers do other significant family members (siblings, grandparents, etc.) or important people in your life who have influenced you (mentors, teachers, etc.) have?

_____

_____

Hobbies/Leisure

Name three activities you enjoy doing in your leisure time:

1. _____

2. _____

3. _____

MENTAL HEALTH INFORMATION

Please check any of the stressors you have experienced over the last 12 months:

___Abusive or violent environment
___Alcohol/drug addiction in the family
___Change in heath
___Change of job or job loss
___Concerns regarding gender
___Concerns regarding other social identity(ies) (race/ethnicity, sexual orientation, religion/spirituality, age, etc.)
___Death of a loved one, if so, relationship(s): _____
___Divorce or breakup
___Experienced a traumatic event
___Experienced acts of discrimination
___Personal injury or illness
___Relationship problems, family
___Relationship problems, significant other(s)

___Other significant stressors or life changes: _____

How long have you been experiencing these problems?

_____

_____

_____

Please list any past or present mental health diagnosis you or anyone in your family have received:

_____

_____

_____

Please check any behaviors/symptoms that apply to you:

___Addictive Behaviors
___Aggressive Behaviors
___Agitation
___Anger and Rage
___Anxiety
___Attention Problems
___Chronic Fatigue
___Chronic Pain
___Concentration Problems
___Depression
___Emotional Overwhelm
___Excessive Guilt
___Excessive Worry
___Fear of Losing Control
___Hallucinations
___High Risk Behaviors
___Hopelessness
___Hyper-vigilance
___Hyperactivity
___Impulsive Behavior
___Irritability
___Lack of Interest
___Low Self-Esteem
___Memory Problems
___Mood Swings
___Motivation Problems
___Nightmares
___Night Terrors
___Obsessive Neg. Thoughts
___Panic Attacks
___Self-Injurious Behavior
___Sexual Concerns
___Sleeping Problems
___Trauma
___Withdrawn

Other(s): _____

How long have you been experiencing the above behaviors/symptoms?

_____

_____

_____

Which of the above behaviors/symptoms are the most concerning to you?

_____

_____

Have you ever tried to injure or kill yourself? **Y or N**

If yes, when did this occur? _____

In the last 6 months, have you been admitted to a psychiatric facility? **Y or N**

In the last 6 months have you been to the ER for any psychiatric reason? **Y or N**

MEDICAL HISTORY

Primary care provider: _____

Medications and/or supplements you are currently taking: _____

_____

Have you experienced any of the following? Please check and describe:

___Chronic Illness: _____

___Surgeries: _____

___Hospitalizations: _____

___Head Injuries: _____

___Eating Problems: _____

___Other Medical Issues: _____

STRENGTHS AND RESOURCES

Please list your most supportive and important relationships. Are you experiencing any current problems with any of these relationships?

_____

_____

_____

Is there anything about your cultural heritage, gender identity, sexual orientation, religion, spirituality, language abilities or other social identities you would like me to know?

_____

_____

_____

_____

_____

Do you identify having any of these **STRENGTHS:**

___ Sense of Humor
___ Good problem solving skills
___ Creative
___ Commonsense
___ Positive Attitude
___ Persistent
___ Curiosity
___ Open-mindedness
___ Thoughtful

Please share any other personal strengths:

_____

_____

Please identify which **RESOURCES** you currently have:

___ Supportive Family
___ Supportive Friends
___ Support Groups or Organizations
___ Financial Resources
___ Religious/Spiritual
___ Community (please list)
_____
_____
___ Others (please describe):
_____
_____

Is there any other information that you feel is important for me to know about you?

_____

_____

_____

_____ _____

Client Name (please print) Client Signature (if necessary) Date

_____ _____

Parent/Guardian Name (please print) Parent/Guardian Signature Date

Jael A. Esquibel, MA, LPC, NCC _____

Therapist Name Therapist Signature Date