

Peace of Mind Counseling, LLC

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CLIENT INFORMATION & 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 the terms of client-therapist confidentiality.

Date: _____

Full Legal Name: _____ Chosen Name: _____

Date of Birth: _____ Age: _____ Ethnicity/Race: _____

Gender Identity: _____ Pronouns: _____

Sexual/Romantic Orientation: _____ Relationship Status: _____

Additional Salient Identities: _____

Religious/Spiritual Affiliation: _____ How often do you practice? _____

Address: _____

Street

(Apt/Unit No.)

City

State

Zip

Cellphone number: _____ Ok to leave message? Y N (Initial) _____

Work or Home number: _____ Ok to leave message? Y N (Initial) _____

E-mail: _____ Ok to email you? Y N (Initial) _____

(e-mail is not considered a confidential medium of correspondence and is only used for logistics)

Emergency contact (for medical emergency only)

Name & phone: _____ Relationship: _____

Do I have permission to contact this person in event of emergency? Y N (Initial) _____

What is your highest education level completed? _____

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

Employed Full Time

Seeking Employment

Military

Employed Part Time

Volunteer

Retired

Homemaker

Student

Other, please describe:

Unemployed

Disabled

HISTORY

Have you previously attended therapy? **Y** **N**

Who did you see? _____

Reason you were seen in therapy: _____

Type of therapy you received: _____

Was the therapy helpful? **Helpful** **Somewhat Helpful** **Not Helpful**

Were you referred to me by someone else? **Y** **N** If so, by whom? _____

Why did they refer you for services, what is their concern? _____

Any medications and/or supplements you are currently taking:

What are the most important qualities you look for in a counselor?

How did you find out about my practice? _____

CURRENT STRESSORS

In your words, please describe why you are seeking counseling at this time:

What would you like to see improve or what would you like to accomplish by engaging in counseling?

I have had problems with the following:

- Abusive or violent environment
- Alcohol/drug addiction in the family
- Change in health
- 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: _____

Please check all that currently apply to you:

Addictive Behaviors
Agitation
Anger
Anxiety
Attention Problems
Chronic Fatigue
Depression
Emotional Overwhelm

Excessive Guilt
Excessive Worry
Hallucinations
Hopelessness
Hyper-vigilance
Hyperactivity
Impulsive Behavior
Irritability

Low Self-Esteem
Nightmares
Self-Injurious Behavior
Sexual Concerns
Sleeping Problems
Withdrawn

Other(s): _____

How long have you been experiencing these problems?

What have you tried so far to help yourself?

Have you ever tried to injure or kill yourself? **Y** **N** If yes, when did this occur? _____

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

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

SUPPORT & 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?

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

By signing, I indicate that I have provided the preceding information to the best of my knowledge.

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