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 or N** (Initial)________

Work or Home number: __________________________________ **Ok to leave message? Y or N** (Initial)________

E-mail: ____ **Ok to email you? Y or 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 or 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 _______________________

What is your current occupation (if applicable)? ____

HISTORY

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

Who did you see? ____

Reason you were seen in therapy: ____________________________________

Type of therapy you received: ______________________________________

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

Were you referred to me by someone else? **Y or 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 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: ____

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 or 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 or 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