

High Mountain Therapy, LLC

P.O. Box 868
Conifer, CO 80433
(303) 493-1401

Jan Switzer, M.A., LPC, CAC III
Licensed Professional Counselor
Certified Addiction Counselor III
jan.switzer@gmail.com

CLIENT INTAKE PACKET

Referred by _____

Client Information

Today's Date: _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ ZIP _____

Mailing Address, if different: _____

Home phone: _____ Business phone: _____ CELL: _____

If necessary, may I call you at work? ____ Yes ____ No At home? ____ Yes ____ No

Where employed: _____

EMAIL: _____

Age: _____ Date of Birth: ____/____/____ Referral Source: _____

Primary Care Physician: _____ Phone: _____

Partnership Status: ____ Partner's name: _____ Age: ____ Years Together ____

Partner's DOB: _____

Occupation: _____ Phone _____ Other Emerg'y Contact: _____

Children: _____

What Brings You In For Counseling At This Time?

What Would You Like to Achieve Through Therapy?

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What Will Be Evidence That This Counseling Has Worked?

Prior Counseling Experience (how often, how long, what worked, what didn't?):

Recent Major Life Changes and Losses:

Suicidal Ideation or Hospitalizations for Emotional Problems:

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Alcohol & Recreational Drug Use (and any problems caused by them):

Medications/Herbs Now Taken:

Any Major Illnesses or Head Injuries?

Work Type and Hours Spent at It Per Week:

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Recreation and Relaxation:

Sleep Patterns:

Eating Patterns:

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Client: _____ **Date:** _____

Personal History

Place of birth: _____ Places lived: _____

Adopted? _____ In foster homes? _____

Siblings, brothers _____, sisters _____. Your birth order? _____

How much contact do you now have with family, and how satisfying is it? _____

Parents: Still married or separated? _____ What was their relationship like?

Mother: Living or deceased? _____ Age, current or at death? _____

Occupation: _____ Your age at time of her death or leaving the home? _____

How did she relate to you as child? _____

How does she relate to you now? _____

Father: Living or deceased? _____ Age, current or at death? _____

Occupation: _____ Your age at time of her death or leaving the home? _____

How did he relate to you as child? _____

How does he relate to you now? _____

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Your Children, names and current ages: _____

How do you relate to them now?:

Did you suffer any physical, emotional or sexual abuse as a child? _____

Religion/Spiritual Path, as a child and as an adult: _____

Describe Any Serious Accidents or Head Injuries? _____

EDUCATION: GED: _____ High School: _____ Trade School: _____

College: _____ Degree: _____ Studies: _____

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What Are You Happy/Satisfied About in Your Life? _____

What Do You Really Want To Change in Your Life? _____

Your Relationship History

How Many Long-term Close Relationships/Marriages Have You Had? _____

Describe How You Feel That You Have Been Successful in Relationships? _____

Describe How You Feel That You Have Been Unsuccessful in Relationships? _____

Friends: Who Are The Most Important People In Your Life Now? _____

Do You Make Friends Easily? _____

How Do You Spend Time With Friends? _____

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Key Medical History and Current Medical Problems: _____

When/Why did you last consult a Physician? _____

Are You Prone to Periods of Strong Anxiety or Panic Attacks? If so, Describe: _____

Have You Experienced Severe Mood Swings or Extended Depression? _____

Do You Have Problems Paying Attention, Staying With Boring Tasks? _____

Anger- *Do You or Your Friends Consider That You Have an Anger Problem?*

Please Add Any Other Information or Concerns that You Believe Will Help You Make the

Most of Counseling:
