THERAPY SERVICES with Dennis Dyck, Ph.D
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CLIENT INFORMATION FORM

Full Legal Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Other Phone: _____ **E-Mail Address:** _____

Do you need restrictions on how we might contact you? ☐ **Yes** ☐ **No** **Explain:** _____

Years of School Completed: _____ **Degree:** _____ **Occupation:** _____

Name of Employer/School: _____

In case of emergency, please contact: _____ **Phone:** _____

Relationship Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Partner Information

Name: _____ **DOB:** _____ **SS#:** _____ **Age:** _____

Years of School Completed: _____ **Occupation:** _____

Place of Employment: _____ **Work Phone:** _____

Length of Relationship: _____

Children's Names & Dates of Birth:

_____

Previous Counseling? ☐ **Yes** ☐ **No** **With Whom?** _____

Who referred you here for counseling? _____

Personal Physician(s): _____

When did you last see your Physician? _____

Please list all medical conditions: _____

_____

Please list all (if any) medications presently used: _____

_____

Please outline the present problem as you see it: _____

_____

_____

_____ _____

Signature of person completing this form Date