www.Iwantabetterlife.net
Gary Dittrich, PC-CR
Licensed Professional Counselor
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CLIENT INFORMATION

(to be filled out by each person receiving treatment)

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully.

Referred By: _____ Date:_____

Client's Name: _____
First Middle Last

Address: _____
Number Street City State Zip

SS#: _____ Birthday: ___/___/____ Sex: _____ Marital Status: _____

Phone: _____ _____ _____
Home Business Cell

Employer: _____ Work Phone: _____

Relationship to payee (check one):
self ___ spouse ___ child ___ step-child ___ adopted child ___ foster child ___ other ___

Person responsible for payment (if different from client)

Name: _____
First Middle Last

Address: _____
Number Street City State Zip

SS#: _____ Birthday: ___/___/____ Sex: _____ Marital Status: _____

Phone: _____ _____ _____
Home Business Cell

Employer: _____ Work Phone: _____

Thank you for answering the following questions. Your answers will help us help you.

Briefly describe your reason for seeking help: _____

_____
_____

List any major health problems for which you are currently receiving treatment:

_____
_____
_____

List medications you are currently taking:

_____
_____
_____

Please check any and all of the following areas in which you are experiencing problems:

_____Nervousness	_____Depression	_____Fears
_____Shyness	_____Sexual Problems	_____Suicidal Thoughts
_____Separation	_____Divorce	_____Finances
_____Frequent Drug Use	_____Frequent Alcohol Use	_____Friends
_____Anger	_____Self-Control	_____Unhappiness
_____Sleep	_____Stress	_____Work
_____Relaxation	_____Headaches	_____Tiredness
_____Legal Matters	_____Memory	_____Grief/Loss
_____Energy	_____Making Decisions	_____Spiritual Concerns
_____Loneliness	_____Inferiority Feelings	_____Concentration
_____Education	_____Career Choices	_____Health Problems
_____Nightmares	_____Marriage	_____Children
_____Appetite	_____Stomach Trouble	_____Family of Origin Issues
_____Bowel Troubles	_____Being a Parent	_____My Thoughts
_____Abuse/Neglect	_____Weight	_____Other: _____

Do you have any history of mental disorders, eating disorders, substance abuse, or child abuse? YES NO
If yes, please explain: _____
_____
_____
_____

Have you tried to commit suicide? YES NO
If yes, please explain: _____
_____
_____

Have you ever felt like seriously hurting someone? YES NO
If yes, please explain: _____
_____
_____

Have you received counseling or psychiatric treatment recently or in the past? YES NO
If yes, please give details (issue, with whom, when, where, etc.): _____

_____
_____
_____

Please indicate any family history of mental disorders, substance abuse or eating disorders.

_____
_____
_____

Are religious or spiritual values important in your life? Yes No Somewhat

Do you wish to discuss them in counseling when relevant? Yes No

Do you have or have you had any legal problems? Yes No
If yes, please explain: _____
_____

Do you have a military history? Yes No
If yes, please explain: _____
_____

Are there any relationships you are unhappy with at the present time? Yes No
If yes, please explain: _____
_____

Are you having financial problems? Yes No
If yes, please explain: _____
_____

What would you like to achieve from treatment? _____
_____
_____

Would you be interested in non-traditional forms of treatment such as phone therapy, e-mail therapy, or coaching? Yes No

Please list every person who lives in your home; beginning with family members:

Name	Age	Relationship	Occupation

I agree to attend all scheduled sessions unless I cancel at least 24 hours in advance. I understand that failure to cancel one day prior to my appointment will result in my being charged the hourly rate for that session. I understand that I am responsible for all fees incurred.

Signature(s): _____ Date: _____

Printed Name: _____ Date:_____