Claudia McGrath
COUNSELING

417 38th Street SW Suite B
Fargo, ND 58103
Phone & Fax: 701-277-0654

Client Information Form

Date:

Name:

Address:

City: State: Zip:

DOB: Age: SS#:

Phone Number:

Home: Work: Cell:

Preferred phone number to be contacted: Home

email:

Reason For Services:

Sex: Female Race Veterans: No

Marital Status: Partnered

How did you hear about this counseling service? Professional Referral

Who referred you to this counseling service?

What circumstances brought you here?

Are you currently seeing anyone for mental health issues? Yes

Who are you seeing?

What medication, if any, do you take?

Do you have any health problems?

Do you have any past or present legal charges?

Do you have health insurance? Yes

Name of Insurance Company

(Please present card to make a copy)

Please read and date the following:

I understand that the payment of these services is my responsibility. I also understand that I have the financial obligation for the services that are not covered by my insurance company.

Client Signature Date

Parent/Guardian Signature Date

(Parental/Guardian Signature required if client is a minor)