Claudia McGrath
COUNSELING

701-261-4472

Client Information Form

Name: _____ **Date:** _____

Address: _____

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

DOB: _____ **Age:** _____

Phone Numbers (Please check preferred contact number)

☐ **Home:** _____ ☐ **Work:** _____ ☐ **Cell:** _____

Email: _____

Reason for Services: _____

_____

Sex: _____ **Race:** _____ **Veteran: Yes / No**

Marital Status: _____

How did you hear about this counseling service? _____

Who referred you to this counseling service? _____

What circumstances brought you here: _____

Are you currently seeing anyone for mental health issues? _____

Who are you seeing? _____

What medication, if any, do you take? _____

Do you have any health problems? _____

Do you have any present legal charges? _____

Please read and date the following:

I understand that the payment of these services is my responsibility at the time of service.

Client signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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