Claudia McGrath
COUNSELING

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Asheville, NC 28803
Phone: 701-277-0654
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Client Information Form

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____SS#: _____

Phone Numbers: *(please check the 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 past or present legal charges? _____

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)