



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:
email:

Reason For Services:

Sex:

Race:

Veterans:

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?

Do you have health insurance?

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)