3220 18th Street South, Suite 1
Fargo, ND 58104 • (701) 364-4040

CLIENT INFORMATION SHEET

DATE ______________________________ NAME ____
PHONE: HOME ____________________ WORK____________________ CELL ______________________
ADDRESS ____________________________________ CITY ______________ STATE _____ ZIP ________
DATE OF BIRTH ______________________________ SEX ( ) MALE ( ) FEMALE
EDUCATION LEVEL ___________________________
RELATIONSHIP STATUS ( )Single ( )Married ( )Widowed ( )Divorced ( )Separated ( )Partnered
NAME OF SPOUSE/PARTNER ____________________ LENGTH OF MARRIAGE ___________________

NAMES AND AGES OF CHILDREN:

NAME	AGE	LOCATION

HOW DID YOU HEAR ABOUT CLARITY COUNSELING:

_________ PHONE BOOK
_________ NEWSPAPER AD
_________ PROFESSIONAL REFERRAL
(specify)

_________ FRIEND
_________ FORMER CLIENT
_________ OTHER
(specify)

YOUR AVAILABLITY FOR COUNSELING SERVICES:

_____ MORNINGS
_____ EARLY AFTERNOONS
_____ LATE AFTERNOONS
_____ EVENINGS

YOUR PLACE OF EMPLOYMENT ____
YOUR JOB TITLE ____
HOURS WORKED IN A USUAL WEEK ____
HAVE YOU USED COUNSELING SERVICES ELSEWHERE? ( ) NO ( ) YES
If yes, please elaborate (when, where, with whom) ____

ARE YOU CURRENTLY TAKING MEDICATION? ( ) NO ( ) YES HERBS? ( ) NO ( ) YES
If yes, name and amount: ____
Prescribed by: ____

ARE YOU ONLINE WITH A COMPUTER? ( ) NO ( ) YES
If yes, how many hours PER DAY: ___________________________ Chatroom contact? ( ) NO ( ) YES

MAY WE CALL YOU AT HOME? ___________________ AT WORK? _____________________________

(Over)

HOW LONG HAVE YOU BEEN EXPERIENCING THE PROBLEMS THAT MADE YOU DECIDE TO GET COUNSELING? ( ) 3-6 Months ( ) 6-9 Months ( ) 9-12 Months ( ) Over 12 Months

PROBLEM CHECKLIST

We would like to know what problems or concerns you are experiencing. This information will aid us in understanding your needs. Please read each item and decide whether or not the area is a problem for you. Also, please rate how serious the problem is. Mark you decision in the columns to the right of the item. All answers are held in confidence.

Please complete each item.	severe problem	moderate problem	mild problem	not a problem
1. Financial problems	________	________	________	________
2. Physical health and/or handicap	________	________	________	________
3. Misuse of drugs or alcohol	________	________	________	________
4. Problems associated with eating	________	________	________	________
5. Spiritual concerns	________	________	________	________
6. Feelings of depression or sadness	________	________	________	________
7. Thoughts of suicide	________	________	________	________
8. Feelings of anxiety or nervousness	________	________	________	________
9. Sexual concerns	________	________	________	________
10. Problems with parents & self	________	________	________	________
11. Parenting concerns	________	________	________	________
12. Threatened or actual abuse/violence	________	________	________	________
13. Boundary violations by professionals	________	________	________	________
14. Problems associated with aging	________	________	________	________
15. Anger or problems with temper	________	________	________	________
16. Unusual fears	________	________	________	________
17. Job stress	________	________	________	________
18. Feelings of loneliness	________	________	________	________
19. Compulsive behaviors	________	________	________	________
20. Issues around childlessness	________	________	________	________
21. Relationship problems	________	________	________	________
22. Trouble relating to others	________	________	________	________
23. Lack of self-confidence	________	________	________	________
24. Body image	________	________	________	________
25. Other, specify	________	________	________	________

My most serious problem is ____