

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 _____

NAME AND AGE OF CHILDREN:

NAME **AGE** **LOCATION**

NAME	AGE	LOCATION

HOW DID YOU HEAR ABOUT CLARITY COUNSELING

() Phone Book () Friend () Widowed () Newspaper Ad () Former Client

() Professional Referral _____ () Other _____

YOUR AVAILABILITY FOR COUNSELING SERVICES

Morning Early Afternoon Late Afternoon 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? NO YES

AT WORK? NO YES

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 your decision in the columns to the right of the item. All answers are held in confidence.

Please complete each item.

1. Financial problems () severe () moderate () mild () N/A
2. Physical health and/or handicap () severe () moderate () mild () N/A
3. Misuse of drugs or alcohol () severe () moderate () mild () N/A
4. Problems associated with eating () severe () moderate () mild () N/A
5. Spiritual concerns () severe () moderate () mild () N/A
6. Feelings of depression or sadness () severe () moderate () mild () N/A
7. Thoughts of suicide () severe () moderate () mild () N/A
8. Feelings of anxiety or nervousness () severe () moderate () mild () N/A
9. Sexual concerns () severe () moderate () mild () N/A
10. Problems with parents & self () severe () moderate () mild () N/A
11. Parenting concerns () severe () moderate () mild () N/A
12. Threatened or actual abuse/violence () severe () moderate () mild () N/A
13. Boundary violations by professional () severe () moderate () mild () N/A
14. Problems associated with aging () severe () moderate () mild () N/A
15. Anger or problems with temper () severe () moderate () mild () N/A
16. Unusual fears () severe () moderate () mild () N/A
17. Job stress () severe () moderate () mild () N/A
18. Feelings of loneliness () severe () moderate () mild () N/A
19. Compulsive behaviors () severe () moderate () mild () N/A
20. Issues around childlessness () severe () moderate () mild () N/A
21. Relationship problems () severe () moderate () mild () N/A

22. Trouble relating to others () severe () moderate () mild () N/A

23. Lack of self-confidence () severe () moderate () mild () N/A

24. Body image () severe () moderate () mild () N/A

25. Other, specify

My most serious problem is: