

**Lutheran Counseling Services, Inc.  
Counseling Client Information Form**

**PLEASE WRITE LEGIBLY**

Counselor \_\_\_\_\_ Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Race \_\_\_\_\_ E-mail \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Sex: Male \_\_\_\_ Female \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Yearly Income: \_\_\_\_\_ Family Income: \_\_\_\_\_

Current Status (circle one): Employed (Full) Employed (Part) Student Un-employed

Place of Employment \_\_\_\_\_

Marital Status (circle appropriate) Single Married Separated Divorced Widow(er)

Minor (under 18) Living together

List any Handicaps: \_\_\_\_\_

Church Affiliation: (circle) Lutheran (ELCA, LCMS, Other) Protestant Catholic Jewish

Other \_\_\_\_\_ None Name of Church \_\_\_\_\_

Church Address \_\_\_\_\_ Pastor \_\_\_\_\_

Who referred you to LCS? \_\_\_\_\_

**IF THE INDIVIDUAL LISTED ABOVE IS NOT THE INSURANCE POLICYHOLDER,  
PLEASE PROVIDE THE FOLLOWING INFORMATION**

Name of Insurance POLICYHOLDER \_\_\_\_\_

Policyholders: Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthday \_\_\_\_\_

Place of Employment \_\_\_\_\_

Work Telephone \_\_\_\_\_ Home Telephone \_\_\_\_\_

**Please attach a legible copy of BOTH SIDES of the POLICYHOLDERS insurance card.**

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**ADDITIONAL FAMILY MEMBERS**

Name	Relationship	Birthdate	School	Grade
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Briefly state what problem or concern brings you to LCS?

Have you ever received counseling from a pastor, psychiatrist or private community resource?  
Yes \_\_\_ No \_\_\_ If yes, please give specifics:

Who is responsible for the payment of fees?

\_\_\_ Self

\_\_\_ Insurance (Sign the Insurance Information Form and include a copy of BOTH SIDES of your insurance card.

\_\_\_ Other: (Name and Address) \_\_\_\_\_  
\_\_\_\_\_