Lutheran Family Service
*For Nothing is Impossible with God*

# CLIENT INFORMATION SHEET

Name: _____Today's Date: _____/_____/_____

Phone Numbers (H): (____) _____-_____ (W): (____) _____-_____ (Cell): (____)_____-_____

Okay to leave a message? (Home) ☐ Yes ☐ No . . . (Work) ☐ Yes ☐ No . . . (Cell) ☐ Yes ☐ No

Address: _____City: _____Zip: _____

☐ I do not want to receive billing statements from LFS at this address. All LFS mail should be sent to this address instead:

_____

Your Email Address: _____

Birth Date: _____ Age: ____ SS#: _____ Marital Status: _____

*(Years)*

Employer: _____ Job Title: _____

Please check a box below which best represents the combined income for all adults living in your household:

| | | |
|---|---|---|
| ☐ To - $14,999 | ☐ $30,000 - 34,999 | ☐ $50,000 - 54,999 |
| ☐ $15,000 - 19,999 | ☐ $35,000 - 39,999 | ☐ $55,000 - 74,999 |
| ☐ $20,000 - 24,999 | ☐ $40,000 - 44,999 | ☐ $75,000 – 99,999 |
| ☐ $25,000 - 29,999 | ☐ $45,000 - 49,999 | ☐ $100,000 – Above |

How many people are provided for from that income? _____

Education: Highest grade/degree completed _____Major area of study _____

Please list all those living in the same household with you:

| *Name* | *Date of Birth* | *Age* | *Relationship* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Person to Contact in Case of an Emergency: _____

Relationship: _____Phone Number: (  ) _____ - _____

***(Over)***

**FOR OFFICE USE ONLY**

*Client Record #:* _____*Site:* _____*Counselor:* _____

*Responsible Party for Bill:* _____*Sliding Fee Scale: $* _____*Co-Pay: $* _____

Your Physician: Name _____ Address _____

Your Psychiatrist: Name _____ Address _____

Please list the name of all medications you are taking, dosage and the condition for which the medication is prescribed.

Medication: _____ Dosage: _____ Condition: _____

Medication: _____ Dosage: _____ Condition: _____

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Medication: _____ Dosage: _____ Condition: _____

Medication: _____ Dosage: _____ Condition: _____

Medication: _____ Dosage: _____ Condition: _____

What is the date of your last medical checkup? _____

Have you ever been hospitalized for psychiatric or psychological problems? Yes____ No ____

If so, when and where? _____

Have you ever been in therapy or received any professional assistance for your problem(s)? Yes____ No____

If so, when and where? _____

Who referred you to this office? ☐ Pastor ☐ Friend ☐ Church Publication ☐ Yellow Pages
☐ Physician ☐ Previous Client ☐ LFS Web Site ☐ Family Member ☐ Other _____

Church membership: _____ Denominational Affiliation: _____

Check anything below that may have contributed to your reason for seeking help at this time:

| | | |
|---|---|---|
| ☐ Feelings over a Death | ☐ Family Problems | ☐ Suicidal Thoughts |
| ☐ Alcohol or Substance Abuse | ☐ Relationship Problems | ☐ Academic Problems |
| ☐ Another's Alcohol or Substance Abuse | ☐ Inability to Concentrate | ☐ Work Related Problems |
| ☐ Spiritual concerns | ☐ Eating Behavior | ☐ Suggested by someone |
| ☐ Depression, Crying Spells | ☐ Sleeping Disturbances | ☐ A Sexual Experience |
| ☐ Stress or Anxiety | ☐ Financial Concerns | ☐ Other:_____ |

Please list any other significant events that have taken place in your life that you might like to discuss with your counselor: _____

_____

_____

_____

_____