

Counseling Services Application

Personal Information

First name	Middle initial	Last name			Today's date	
Mailing/Street address			City	State	Zip	Home phone
			Business phone:			Cell Phone:
Birth date	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Employer name:		
Email address:				List present or previous health problems including any medication you are currently taking:		
Bishop's name:		Ward	Stake	Home Phone	Work Phone	Cell Phone
Bishop's address:		Street	City	State	Zip	

Spouse Parent Information if under 18

First name	Middle initial	Last name			Marriage date	
Street address			City	State	Zip	Home phone
			Business phone			
Birth date	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female					
List present or previous health problems						
List any medications you are currently taking						

Children's Information

Instructions: List all children

Name	Birth date	Lives with you?	Name	Birth date	Lives with you?

Insurance Information

Payment Arrangements: Client Insurance

(1) Company name	Policyholder	Policyholder's date of birth	Applicant's relationship to policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Insurance Company Address			City	State	Zip
			Phone		
	Policy number	Co-payment amount	Group number		
(2) Company name	Policyholder	Policyholder's date of birth	Applicants relationship to policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Street address			City	State	Zip
			Phone		
Policyholder's SS #:	Policy number	Co-payment amount	Group number		

Other Information (PLEASE COMPLETE THIS SECTION)

What do you hope to change or accomplish by seeking help at this time? (Use the back of the form if more room is needed.)

List any agencies or other professionals who have provided you counseling services in the past. (Use the back of the form if more room is needed.)

Signature	Signature
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