Eleos Christian Counseling Services
Client Contact & Referral Information

Today's Date: _____

Client Name (s):_____ **DOB:**_____

Client Name (s):_____ **DOB:**_____

If the client above is a child
Parents or Guardian Names: _____

_____ _____ _____ _____
Home Address City State Zip

(___) _____ (___)_____
Primary Phone # Name Secondary Phone # Name

_____ (___) _____
Email Address Emergency Contact Name

How did you hear about Stephanie Hotaling, LMFT or Eleos Christian Counseling?

Professional referral: Name _____

Personal referral: Name _____

My pastor / church: Name _____

Insurance Company Directory_____

Do you attend a local church? No Yes _____
Church Name

Do you plan to use your Health Insurance or Employee Assistance Program to help pay for your therapy sessions?

Yes No

If you answered "No" to the previous question, would prefer to use fee for service?
What is your estimated annual gross (pre-tax) income for your household?

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