

**Kirsten Oelklaus, LSCSW, Inc**  
**Client Data Sheet**



Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
Last First Middle Initial

Home Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

E-Mail \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

\*\*\*Insured \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Billing Address (if different from above) \_\_\_\_\_

Employers Name \_\_\_\_\_ Your Position \_\_\_\_\_

Address \_\_\_\_\_ Years with Employer \_\_\_\_\_

Education (# of Years) \_\_\_\_\_ Highest Degree \_\_\_\_\_ Usual Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Others in your family or living in the home with you:

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____

In Emergency, Notify: (Please name two)

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to you \_\_\_\_\_ Relationship to you \_\_\_\_\_

Family Physician: \_\_\_\_\_

Name Phone

Address City State Zip

Your Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

(This signature does not authorize release of information or obligate you in any way to InSight Counseling, LLC. or your Independent Practitioner. It is requested for your protection only)

\*\*\*Regarding insurance: It is the responsibility of the client to file claims with their insurance company. Your Practitioner does not maintain a supply of insurance forms. Payment is required at the time of service. InSight Counseling, LLC is home to a network of Independent Practitioners.