Children's Home Society of Minnesota
Lutheran Social Service of Minnesota

1605 Eustis Street
Saint Paul, MN 55108
800.952.9302 | 651.646.7771 | chlss.org

# COUNSELING REPORT

**This report is required for an applicant with a history of any type of counseling by a therapist or other mental health professional or a pastor, if applicable.**

Applicant Name _____

Address _____

City, State Zip _____

Date of Birth _____

**Please return completed form to:**

Children's Home/LSS Adoption
Attn: Domestic Program Specialist
1605 Eustis Street
Saint Paul, MN 55108
Fax: 651.255.2292

I agree that the findings of this report be shared with CH/LSS. This consent is valid for one year from the date of signature.

APPLICANT | Signature _____ Printed Name _____ Date _____

_____ *I authorize Children's Home Society & Lutheran Social Service to have ongoing written & verbal contact with this provider listed in this report.*
*Initials*

_____ *I/We certify that I/We have retained a copy of this signed document for my/own records.*
*Initials*

Diagnosis:

Does the person in this report have any history of hospitalization for mental health reasons? ☐ Yes ☐ No

Please list the dates and type of service and length of treatment:

Please list the major areas of focus:

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What is your impression of any impact this diagnosis/history may have on functioning as an adoptive parent?

Please include any additional comments here:

**PROVIDER INFORMATION**

License Number _____

Clinic Name_____

Clinic Address _____

Clinic Phone Number_____

To the best of my knowledge, I have disclosed all health compromising information about the above-named patient.

PROVIDER | Signature_____ Printed Name _____

Date_____