The Helping Heart
Leann Gabel, M.A., L.P.C.
CLIENT INFORMATION

Last Name _____ First Name _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Telephone Numbers: Home _____ Cell _____ Work _____

Preferred Contact Number: ❑Home ❑Cell ❑Work
May I leave a message at: Home ❑Yes ❑No Cell ❑Yes ❑No Work ❑Yes ❑No

Email Address* _____

Occupation _____ Employer's Name _____ Church/Religious Preference _____

Partner/Spouse First Name _____ Partner/Spouse Last Name _____ Date of Birth _____

Partner/Spouse Home Address _____ City _____ State _____ Zip Code _____

Telephone Numbers: Home _____ Cell _____ Work _____

Preferred Contact Number: ❑Home ❑Cell ❑Work
May I leave a message at: Home ❑Yes ❑No Cell ❑Yes ❑No Work ❑Yes ❑No

Partner/Spouse Email Address* _____

Occupation _____ Employer's Name _____ Church/Religious Preference _____

Your Current Relational Status:
❑Never married ❑Married ❑Divorced ❑Separated ❑Engaged ❑Dating ❑Widowed For how long? _____

Previous Marriages & Years Married For You

_____

_____

Previous Marriages & Years Married For Your Partner/Spouse

_____

_____

Name(s) of Child/Children	Age	Living at home?
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No

Have you ❑previously worked with or are you ❑currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time you saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

Has your spouse/partner ❑previously worked with or is s/he ❑currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time s/he saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

What are the reasons for you considering therapy at this time? _____

_____

Please list all of the prescribed medications you are currently taking. Include those of your spouse/partner if s/he will be attending therapy with you.

Client (check one)	Medication	Dosage	Prescribing Physician
❑ Self ❑ Spouse/Partner	_____	_____	_____
❑ Self ❑ Spouse/Partner	_____	_____	_____
❑ Self ❑ Spouse/Partner	_____	_____	_____

Are you and/or your spouse/partner currently being treated by a physician for any medical conditions?
If so, please provide a brief description. _____

_____

_____

_____.

Has anyone in your or your spouse/partner's immediate or extended family ever been treated or hospitalized for substance abuse, addictive or compulsive disorders, or any other psychiatric conditions?
If so, please provide a brief description. _____

_____

_____

_____.

Who, other than your spouse/partner, should be notified in case of an emergency?

_____ _____ _____
Last Name First Name Phone #

_____ _____ _____ _____
Street Address City State Zip Code

_____
Relationship

How did you learn about The Helping Heart?

❑Referral from friend/family ❑Referral from physician/therapist ❑Phonebook ❑Internet ❑Other _____

May we send a note of gratitude to the person who referred you? ❑Yes ❑No
May we include your name in the note? ❑Yes ❑No

I hereby attest that the information provided above is current and accurate to the best of my knowledge.

_____
Date

_____ _____
Client Signature Please print your name

_____ _____
Client Signature Please print your name