The Helping Heart

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CLIENT INFORMATION

1)_____ _____ _____

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

2)_____ _____ _____

Guardian Name Guardian Phone Number Relationship

_____ _____ _____ _____

Guardian Address(if different than above) 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

_____

Guardian Email Address*

_____ _____ _____

Occupation Employer's Name Church/Religious Preference

3)_____ _____ _____

Guardian Name Guardian Phone Number Relationship

_____ _____ _____ _____

Guardian Address(if different than above) 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

_____

Guardian Email Address*

_____ _____ _____

Occupation Employer's Name Church/Religious Preference

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

If raised by someone other than birth/blood parents, please explain: _____
_____

Parents divorced? Yes____ No____ If yes, what was your age?

Parents deceased? Yes____ No____ If yes, what was your age? Father_____Mother_____

List brothers and sisters in birth order, beginning with the oldest (including yourself):

Name:	Age	Living at home?
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No

Have you/your child ❑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? _____

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

_____

Please list all of the prescribed medications you(your child) are/(is) currently taking.

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

Are you/your child currently being treated by a physician for any medical conditions? If so, please provide a brief description.

_____

_____

_____.

Are you/your child currently receiving any other support services/special placements through your school or community? If so, what services/placements.

_____

_____

_____.

School currently attending: _____ Grade:_____

Who would you like to 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 _____

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/Guardian Signature if minor Please print your name

_____ _____
Client Signature/Guardian Signature if minor Please print your name