Date: ___________________ County of Residence: ____________________

General Information

If seeking services for a minor child, please complete this section with the legal parent / guardian's information.

First Name __________________________________ Last Name _____________________________________

Gender __________________ Race / Ethnicity _____________________ DOB (mm/dd/yyyy) ______________

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Self-Identify:__________________

Address: _______________________________ City _____________________ State ________ Zip ___________

Main Phone (_____)_________-_______________ Type (circle one): Cell Home Work

Secondary Phone (_____)_________-_______________ Type (circle one): Cell Home Work

Can we leave a voice message? ☐ Yes ☐ No Can we send text messages / reminders? ☐ Yes ☐ No

Email Address ____ **Your email is never shared*

Veteran Status: ☐ I am not a Veteran ☐ I am a Veteran ☐ I choose not to identify my Veteran Status

Are you a registered organ donor? ☐ Yes ☐ No ☐ I don't know

Are you an organ donor recipient? ☐ Yes ☐ No

Emergency Contact _____________________________ *Relationship* ________________ *Phone* ________________

Children Needing Services

Please complete the below information for any children that will use Heartlinks

1

Full Name __________________________________ Preferred Name: ______________DOB _____________

Gender ________________________ Race / Ethnicity _______________________ Age at time of loss ______

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Self-Identify:__________________

2

Full Name __________________________________ Preferred Name: ______________DOB _____________

Gender ________________________ Race / Ethnicity _______________________ Age at time of loss ______

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Self-Identify:__________________

3

Full Name __________________________________ Preferred Name: ______________DOB _____________

Gender ________________________ Race / Ethnicity _______________________ Age at time of loss ______

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Self-Identify:__________________

What is your relationship to the minor child(ren)? ____________________________________

Who do the children live with? ____

About Your Loss

Name of the person who died ________________________________ Date of Death ____________________

Relationship to you _____________________________ Relationship to children _______________________

Cause of death ____

Was this person: ☐ Organ Donor ☐ Organ Recipient During Their Life ☐ Unknown ☐ None Apply

Any other details you'd like to share? ____

Brief Mental Health History

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, when? _______________

Have you ever had outpatient treatment by a psychiatrist? ☐ Yes ☐ No If yes, when? _______________

Have you ever received counseling in the past? ☐ Yes ☐ No ☐ I am currently seeing a counselor

If yes, when and by whom? ____________

Please list any psychiatric medication you are currently taking or have taken:

Current Medication

____

____

____

For Counseling Services:

Appointment Availability: *Select all that apply*

☐ Morning ☐ Afternoon ☐ Evening

Type of visit preferred:

☐ In Person Only ☐ Virtual ☐ Either

For Group Services:

☐ ***Check this box if you are interested in attending grief support groups***

Where did you hear about us?

____