Grief Counseling Intake Form

Name: ________________________ **Date:** ____________

Address:

____

Phone: (home): ____________________________ (Cell): ______________________________

Client referred by: ____

Deceased Person's Name________________________ **Age**_____

Date of Death________________

Relationship to you______________________

Circumstances of Loss:____

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What special concerns do you want to address through grief counseling? Your goals?

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Are you currently receiving any other counseling services? If so, for what issues? (Generalize)

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Do you feel there may be any level of psychological danger?_____ Please briefly explain:

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Please check any of the reactions you *currently* may be experiencing:

___ loneliness ___anger ___guilt ___fear ___relief ___ ___depression eating/sleep disturbances ___restlessness ___negative attitude ___fatigue ___lack of motivation ___anxiety ___hopelessness ___ loss of meaning ___fatigue ___forgetfulness ___worrying ___feeling 'foggy' ___mood swings ___poor concentration ___joyless ___doubting beliefs ___future-less ___irritability ___shame ___sense of isolation ___difficulty with others' reactions ___difficulty with the way others are showing or not showing their grief ___Suicidal thoughts or ideation

Additional Information For Pet Loss: (If Applicable)

Pet's Name:____________________ **Age:** _______ **Species:** ______________________**Date of Death**:______________

Length of Relationship with Pet: ____

Circumstances of Loss:

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