Grief Counseling Intake

Name______________________________ Date__________

Address____
Street City State Zip

Phone Number: Home__________Work__________Mobile__________

Is it ok to leave a message? Yes ☐ No ☐

Is it ok to use texting for appointment scheduling/confirmations? Yes ☐ No ☐

Email ____________________Date of Birth__________Age________

Emergency Contact____________________ Relationship__________Phone number__________

Information about the Deceased

Name of Deceased____________________Relationship to Deceased____________________

Date of Death________Age at Death________ Place of Death____________________

Cause of Death____

Was the person who died a hospice patient? Yes ☐ No ☐

If yes, please give the name of the hospice____________________________

Have you experienced any other losses in the past year?____________________

Personal Information/Life Situation

Marital Status: Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other____________

Household members/Significant Others:

Name____________________Age________Relationship__________
Name____________________Age________Relationship__________
Name____________________Age________Relationship__________

Are you currently working? Yes ☐ No ☐ What kind of work do you do?______________

Please list any mental health concerns/diagnosis____________________________

Are you currently receiving counseling services from another provider? Yes ☐ No ☐
Therapist Name______________________________Phone__________

Have you seriously considered or attempted suicide? Yes ☐ No ☐
If yes, please explain:______________________________

Have you been hospitalized for physical/mental health reasons within the last 5 years?
Yes ☐ No ☐ If yes, please explain:______________________________

Please list any current medical conditions:______________________________

Please list any current medications you are taking:______________________________

Have you ever abused drugs or alcohol? Yes ☐ No ☐
If yes, please explain ______________________________

People who are grieving may experience any of the following symptoms. Do any of these apply to you?

- ☐ Irritability
- ☐ Fatigue
- ☐ Weight gain or loss
- ☐ Diminished self esteem
- ☐ Change in appetite
- ☐ Nightmares/Insomnia
- ☐ Headaches
- ☐ Loneliness
- ☐ Hallucinations
- ☐ Poor concentration
- ☐ Restlessness
- ☐ Excessive guilt
- ☐ Hopelessness
- ☐ Excessive worry
- ☐ Tension/Stress
- ☐ Health problems
- ☐ Sexual problems
- ☐ Confusion
- ☐ Alcohol/Substance use
- ☐ Decreased energy

On a scale of 1-5, Please check the number that best describes your experience at this moment.

	Not True				**True**
I understand how grief is affecting me	☐1	☐2	☐3	☐4	☐5
I have tools to cope with my grief effectively	☐1	☐2	☐3	☐4	☐5
I can handle the intense feelings that go with grief (i.e. guilt, anger, fear, sadness)	☐1	☐2	☐3	☐4	☐5
I know what kind of support I need in my grief and where to find it.	☐1	☐2	☐3	☐4	☐5
I believe that I can go on living and loving even though my loved one is gone.	☐1	☐2	☐3	☐4	☐5

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Please list any support resources available to you at this time (i.e. friends, family, church, community groups, activities):____

What prompted you to seek grief counseling and what are you hoping to get out of your sessions?

____

Anything else you would like your counselor to know about you?

____

Where did you hear about Halcyon Grief Counseling services?______________________

Preferences (please know that we will do our best to accommodate but cannot guarantee availability)

Location: Home ☐ Counseling Office ☐

Day of week (mark all that apply): Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Time of day (mark all that apply): Morning ☐ Afternoon ☐ Evening ☐

Please send completed intake to:
griefsupport@myhalcyon.org or
Halcyon Grief Support,
P.O. Box 177
Mead, CO 80542

Upon receipt of this intake, a counselor will contact you to schedule counseling services. If you have any questions, please call **Halcyon Grief Services** at **720-325-2987.**