Halcyon HOSPICE & Palliative Care

Child Name:_____

CHILD COUNSELING INTAKE

To be filled out by Parent/Guardian

Parent/Guardian Name_____ Date_____

Address_____
Street City State Zip

Phone Number: Home_____ Work_____ Mobile_____

Email _____ Occupation_____

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

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

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

Household Members/Significant Others:

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Emergency Contact_____ Relationship_____ Phone number_____

Where did you hear about Halcyon Grief Counseling services?_____

Information about the Child

Child's Name_____ Date of Birth_____ Age_____

Child's School_____ Grade level_____

How would you describe your child's personality? (Please check all that apply)

☐ Quiet, reserved	☐ Active	☐ Sensitive
☐ Slow to warm up to people	☐ Easy going	☐ Likes one-on-one
☐ Leadership qualities	☐ Tires easily	☐ Sad
☐ Talkative	☐ Calm	☐ Holds in emotions
☐ Worries	☐ Likes group activities	☐ Easily frustrated
☐ Night owl	☐ Angry	

Information about the Deceased

Name of Deceased_____ Child's Relationship to Deceased_____

Date of Death_____ Age at Death_____ Place of Death_____

Cause of Death_____

Does your child know the cause of death? ☐ Yes ☐ No

Was the child present at time of death? ☐ Yes ☐ No

Child's response at Time of Death_____

Can you describe the relationship your child had with the person who died?_____

Did your child attend a memorial and or funeral? ☐ Yes ☐ No

If yes, what was their reaction?_____

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

If yes, please give the name of the hospice_____

Child's Health & Personal History (please check all that apply and briefly explain in the space provided)

Does your child have any health issues or concerns? ☐ Yes ☐ No

Please describe:_____

Does your child have any allergies? ☐ Yes ☐ No

Please describe:_____

Does your child have any current and/or previous mental health issues or learning challenges? ☐ Yes ☐ No

Please describe:_____

Has your child been in counseling before? Yes ☐ No ☐

Is your child currently receiving counseling services from another provider? Yes ☐ No ☐
Therapist Name_____ Phone_____
If yes, please explain:_____

Is your child currently taking any medications? ☐ Yes ☐ No ☐
Please list type and reason:_____

Teens: Does your teen have any current and/or previous issues with substance abuse?
☐ Alcohol ☐ Prescription drugs ☐ Recreational drugs ☐ Other:_____

What additional stressors are currently in your family's or child's life?

☐ Financial
☐ Legal
☐ Family/Relationships
☐ Death of family member
☐ Moved schools
☐ Moved classrooms
☐ Change in child care
☐ Moved homes
☐ Death of a pet
☐ Illness
☐ Change in job of parent(s)
☐ Change within home (i.e new sibling, others living in home)
☐ Change in primary living situation
☐ Other:_____

How many hours of sleep does your child average each night? _____

Has your child experienced any changes in appetite? ☐ Increase ☐ Decrease ☐ Weight loss/gain

Has your child recently experienced and changes in energy level? ☐ Increase ☐ Decrease

Has your child experienced any other recent losses or significant change? ☐ Yes ☐ No

Please describe:_____

Who or what is your child's primary source of emotional support?
☐ Family ☐ Friends ☐ Teacher/school counselor ☐ Church/Faith Community
Other:_____

What concerns do you have regarding your child? (Please check all that apply)

☐ Multiple losses or stressors
☐ Anger, guilt, anxiety, fear, sadness, worries,
☐ Difficulty coping
☐ Need additional support
☐ Relationship concerns/issues
☐ Grief support and education for parent/guardian
☐ Other: _____

What do you hope to gain from counseling (please check all that apply)

☐ Information about the grief process
☐ Increase existing support system
☐ Expression of Grief
☐ Develop coping tools/resources for self-care
☐ Increased confidence in coping with emotions
☐ Other:_____

As your counselor, is there anything else you would like me to know about your child or family?

_____

Please send completed intake to: griefsupport@myhalcyon.org
Halcyon Grief Support, P.O. Box 177 Mead, CO 80542 Fax 303-394-0871

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.**