

BEREAVEMENT COUNSELING CLIENT INFORMATION

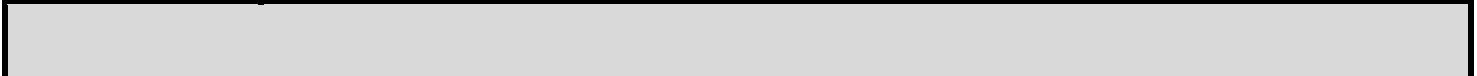
Last Name				First Name			Middle Initial	
Birth Date	/	/	Age		Last 4 digits of SS#	XXX - XX - _ _ _ _		
Street Address								
City				State			Zip Code	
Home Phone				Cell Phone			Work Phone	
Emergency Contact						Relationship		
Emergency Cell Phone				Emergency Second Phone				
Days Available for Sessions				Time of Day Available for Sessions				

INFORMATION ABOUT THE DEATH/LOSS

Describe loss or Death		
Date of Loss/death		
What were the circumstances surrounding the Loss/death?		
PREVIOUS LOSSES (include people, pets, jobs and home losses)	WHEN (mm/yy)	HOW DID YOU RESPOND?

INDIVIDUAL COPING WITH THE MOST CURRENT LOSS

What prompted the call for grief counseling?	
Any symptoms or behaviors of concern for you?	
How long have you noticed these changes in you?	



HISTORY			
<input type="checkbox"/> Anger	<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Sleep Issues
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Learning Issues	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Cigarette Smoking	<input type="checkbox"/> Memory Issues	<input type="checkbox"/> Substance Use
<input type="checkbox"/> Attention-Deficit / Hyperactivity Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Psychotic Episode	<input type="checkbox"/> Previous Suicide Attempt
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Illness in Remission	<input type="checkbox"/> Previous Trauma/Abuse
Describe Any Family and/or Work Issues			
Family Member(s) Substance Use/Abuse			
Supportive People in Life			
Interests			

MEDICATION LIST	PURPOSE OF MEDICATION	PRESCRIBING PHYSICIAN

CURRENT PHYSICIANS AND COUNSELING SUPPORT (Include name, practice name, city and phone number)	
Primary Care Physician <input type="checkbox"/> Release of Information signed on _____	
Psychiatrist <input type="checkbox"/> Release of Information signed on _____	
Counselor/ Social Worker <input type="checkbox"/> Release of Information signed on _____	
Group Support	

Kathy Cherven RN, LCPC
Loss and Grief Counseling