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			
☐ Anger	☐ Bi-Polar Disorder	☐ Eating Disorder	☐ Sleep Issues
☐ Anxiety	☐ Chronic Pain _____	☐ Learning Issues _____	☐ Schizophrenia
☐ Alcohol Use	☐ Cigarette Smoking	☐ Memory Issues	☐ Substance Use _____
☐ Attention-Deficit / Hyperactivity Disorder	☐ Depression	☐ Psychotic Episode	☐ Previous Suicide Attempt
☐ Autism Spectrum Disorder	☐ Developmental Delay	☐ Illness in Remission _____	☐ 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 ☐ Release of Information signed on _____	
Psychiatrist ☐ Release of Information signed on _____	
Counselor/ Social Worker ☐ Release of Information signed on _____	
Group Support	

Kathy Cherven RN, LCPC
Loss and Grief Counseling