Uplifted CARE
FOUNDED AS HOSPICE OF KANKAKEE VALLEY

Community Grief Center
3115 N. 1000 W. Rd.
Bourbonnais, IL 60914
815.939.4141 | upliftedcare.org

BEREAVEMENT COUNSELING CLIENT INTAKE FORM CHILD/TEEN

Parent/Guardian Information:

NAME:		DATE:
ADDRESS:	CITY/TOWN:	ZIP:
HOME PHONE:	MOBILE PHONE:	EMAIL:
MAY WE IDENTIFY OURSELVES/LEAVE A MESSAGE?:		
HOME: YES☐ NO☐	MOBILE: YES☐ NO☐	EMAIL: YES☐ NO☐
RELATIONSHIP TO CHILD/TEEN:		
How did you learn about our Bereavement Counseling?:		

Child/Teen Information:

NAME:		BIRTHDATE:
SCHOOL DISTRICT:	SCHOOL:	GRADE:
ANY NEW CONCERNS AT SCHOOL:		
ADDITIONAL/SECONDARY EMERGENCY CONTACT FOR CHILD/TEEN:		
NAME:	PHONE:	RELATIONSHIP:

Current Household Members:

NAME:	AGE:	RELATIONSHIP TO CLIENT:

Significant Loss Experienced (death, relationships, etc.):

Loss: When:

Primary supportive people for your child/teen:

Name: Relationship:

At this point in time, what is the most difficult thing for your child/teen related to the death of their loved one?

What do you hope will improve/change for your child/teen as a result of Bereavement Counseling?

ASSESSMENT:

Please complete this assessment and check the boxes that best describe your child/teen's current status:

Current Status:	Never	Sometimes	Often	Always
Sad	☐	☐	☐	☐
Lonely	☐	☐	☐	☐
Nervous/Restless	☐	☐	☐	☐
Angry	☐	☐	☐	☐
Guilty	☐	☐	☐	☐
Fearful	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Low Energy/Motivation	☐	☐	☐	☐
Exhausted	☐	☐	☐	☐
Depressed	☐	☐	☐	☐
Weight Change	☐	☐	☐	☐
Sleep Problems	☐	☐	☐	☐
Relationship Problems	☐	☐	☐	☐
Problems at Home	☐	☐	☐	☐
Problems at School	☐	☐	☐	☐
Unable to Control Emotions	☐	☐	☐	☐

Coping Skills You Have Used:	
Keeping Busy	☐
Talking with Others	☐
Gaming	☐
Reading	☐
Writing	☐
Friends	☐
Physical Activity	☐
Sports	☐
Music	☐
Spirituality/Faith	☐
Nature/Outdoors	☐
Art/Crafts	☐
Clubs/Scouts	☐
Dance	☐
Movies/Streaming/TV	☐
Others:	☐

Have You or Your Child/Teen Ever:	Yes	No	If Yes, when?
Had Anxiety Disorder or panic attacks?	☐	☐	_____
Been involved in a violent incident?	☐	☐	_____
Experienced depression?	☐	☐	_____
Had thoughts of suicide?	☐	☐	_____
Had an eating disorder?	☐	☐	_____
Been emotionally, physically or sexually abused?	☐	☐	_____
Had delusions or hallucinations?	☐	☐	_____
Had treatment for any of these?	☐	☐	_____

AGREEMENT FOR SERVICES:

INFORMED CONSENT

Bereavement Counseling Services are provided free-of-charge to anyone, regardless of a client's age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

Clients will participate in the development of their treatment plan and have the right to receive clinically appropriate care suited to their needs.

Counseling sessions are about an hour long. If it is necessary to cancel an appointment, please let us know as soon as possible. ***After 2 cancellations or calls to reschedule, the bereavement counselor has the right to discontinue counseling services at that time. Bereavement counselor will review the circumstances with client and reschedule again at the bereavement counselors discretion.***

Appointments start on time. If client is late, ending the appointment at the original ending time will be at the discretion of the counselor.

Clients have the right to terminate counseling at any time. It may become apparent to the client or counselor that services are no longer effective or sufficient. The counselor may suggest client seeks alternative or additional treatment. Counselor will make every effort to provide clients with appropriate referrals for other qualified professionals.

Grieving and healing is a process. The many documented benefits of grief counseling include clients maintaining a bond with the loved one who has died, clients experiencing a reduction in distressing emotions, clients feeling validated and understood, clients experiencing a positive impact on relationships and clients realizing improved coping. However, thinking about and discussing one's personal grief experience can be challenging at times. It is important to know this is a component of the grief and healing process.

I consent for my child to receive bereavement counseling services from UpliftedCare. I understand the limits of confidentiality, as described in UpliftedCare's Notice of Privacy Practices. These limits of confidentiality include: When there is evidence of child abuse or neglect, or when a client poses a serious threat to the health/safety of their self and/or other(s).

Parent/GuardianSignature_____Date_____

I acknowledge I have received a copy of UpliftedCare's Notice of Privacy Practices. I understand this document provides an explanation of the ways in which my information may be used or disclosed by UpliftedCare and includes my rights regarding my personal information.

Parent/Guardian Signature _____Date_____