

## BEREAVEMENT COUNSELING CLIENT INTAKE FORM

### Client Information:

NAME:		BIRTHDATE:	
ADDRESS:		CITY/TOWN:	ZIP:
HOME PHONE:	MOBILE PHONE:	EMAIL:	
MAY WE IDENTIFY OURSELVES/LEAVE A MESSAGE?:			<i>Check this box if you do <b>NOT</b> wish to receive communication from UpliftedCare via email</i>
HOME: YES___ NO___    MOBILE: YES___ NO___    EMAIL: YES___ NO___			
IN CASE OF EMERGENCY, PLEASE NOTIFY: NAME:			
PHONE:		RELATIONSHIP TO CLIENT:	
How did you learn about our Bereavement Counseling?:			

### Current Household Members:

NAME:	AGE:	RELATIONSHIP TO CLIENT:

### Significant Loss You Have Experienced (death, relationships, employment, etc.):

Loss:	When:

### Primary Supportive People:

Name:	Relationship:

SELF ASSESSMENT:

Current Status:	Never	Sometimes	Often	Always	Coping Skills You Have Used:
Sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keeping Busy <input type="checkbox"/>
Lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Talking with Others <input type="checkbox"/>
Nervous/Restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading <input type="checkbox"/>
Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing <input type="checkbox"/>
Guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spirituality/Faith <input type="checkbox"/>
Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity <input type="checkbox"/>
Poor Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Music <input type="checkbox"/>
Low Energy/Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Art/Crafts <input type="checkbox"/>
Exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drugs <input type="checkbox"/>
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____ <input type="checkbox"/>
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____ <input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Relationship Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems at Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems at Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unable to Control Emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Have You Ever:	Yes	No	If Yes, when?
Been emotionally, physically or sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been involved in a violent incident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Experienced depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had thoughts of suicide?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Anxiety Disorder or panic attacks?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had delusions or hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had treatment for any of these?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

What do you hope will improve/change as a result of Bereavement Counseling?

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 counselor's 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.

For safety reasons, no children under the age of 18 are to be left unattended in the lobby while their parent/guardian is in session with a 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 to receive bereavement counseling services from UpliftedCare. I also consent to receive services via telehealth/video conferencing, if applicable. 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).

Signature \_\_\_\_\_ 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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