Transitions GriefCare
Formerly Horizons Grief Center

ADULT INTAKE FORM

Contact Information

Today's Date: _____

What is your preferred language? ○ English ○ Spanish ○ Chinese ○ Other: _____

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ **Age:** ____

Pronouns: ○ she/her ○ he/him ○ they/them ○ Other: _____

Address: _____

Phone Numbers
Home: _____ Work: _____ Cell: _____

E-mail (optional): _____

Would you like to receive monthly email notices about our upcoming events and offerings? ○ Yes ○ No

May we leave messages on your voicemail? ○ Yes ○ No

What is the best way to reach you? ○ Phone ○ Email

Emergency Contact:
Name: _____ Phone #: _____ Relationship: _____

Referred by: _____

General Information

Please state what you hope to achieve through counseling (e.g., goals):

On a scale of one to ten, how would you rate your current level of support from friends, family, coworkers, faith community, etc.?

Not Supported	1	2	3	4	5	6	7	8	9	10	Very Well-Supported
	○	○	○	○	○	○	○	○	○	○	

Are you currently seeing or have you seen a mental health professional in the past? ○Yes ○No

If yes, please list the name of provider and nature of services: _____

Are you currently taking any medication for anxiety, depression, or another mood disorder? ○Yes ○No

If yes, please list the name(s) of medication(s) and their purpose: _____

How long have you been taking this medication? (e.g., 2 weeks, 2 years, etc): _____

Prescribing physician and contact information: _____

Have you had suicidal thoughts or thoughts of self-harm in the past? ○Yes ○No

Do you have suicidal thoughts or thoughts of self-harm presently? ○Yes ○No

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Have you ever been hospitalized for mental health reasons? ◯Yes (When? _____) ◯No

Do you presently use street or recreational drugs, or take prescription meds differently than prescribed?
◯Yes ◯No

Do you consume alcohol? ◯Yes ◯No Describe frequency and/or amount: _____

Do you have concerns, or have friends/family ever voiced concern about your use of substances?
◯Yes ◯No

Are you currently impacted by any of the following?
☐ Job Loss/Changes ☐ Additional Death ☐ Move ☐ Financial challenges ☐ Relationship Strain

Other significant life occurrences (e.g., divorce, weddings, births, etc.): _____

Do you have a history of trauma (i.e., sexual assault, domestic violence, physical or emotional abuse)?
◯ Yes (please list): _____ ◯ No

Bereavement Information

Name of deceased: _____ **Date of Death:** _____

Your relationship to deceased: _____

Did the deceased receive hospice services? ◯ Yes ◯ No If so, where? _____

This loss was… (please check any that may apply):
☐ Sudden/Unexpected ☐ Traumatic ☐ Prolonged ☐ Peaceful ☐ Painful ☐ Other: _____

In a few words, how would you describe your relationship with the deceased?
(i.e. close, conflicted, distant, etc.): _____

Grief/Coping Information

Overall, how do you feel you are coping since the death of your loved one? On a scale of one to ten, select the number that best describes how well you are coping today.

Not Well	1	2	3	4	5	6	7	8	9	10	Coping Well
	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	

Please list any coping strategies that you find helpful:

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Common Grief Reactions

Below is a list of common grief reactions. Please check the changes that you've noticed as a result of your loved one's illness or death.

Work

- ☐ Distracted at work
- ☐ Difficulty getting work done
- ☐ Tardiness/absences from work
- ☐ Anxiety about or unwillingness to go to work
- ☐ Other: _____

Family/Friends

- ☐ Increased fighting with family/friends
- ☐ Withdrawal from family/friends
- ☐ Isolation
- ☐ Other: _____

Sleep Changes

- ☐ Dreams about the deceased or the death
- ☐ Increased fatigue
- ☐ Trouble going to sleep
- ☐ Restlessness at night
- ☐ Nightmares
- ☐ Other: _____

Feelings

- ☐ Feelings of sadness
- ☐ Inconsolable crying
- ☐ Guilty feelings
- ☐ Anger outbursts or rage
- ☐ Irritability
- ☐ Numbness/shock
- ☐ Anxiety
- ☐ Feelings of relief
- ☐ Other: _____

Fears/Worries

- ☐ Financial distress
- ☐ Fear of death
- ☐ Fear of other family member dying
- ☐ Fear of new experiences

Behaviors and Somatic Reactions

- ☐ Daydreaming
- ☐ Decreased ability to concentrate
- ☐ Decreased energy level or feeling overly tired
- ☐ Withdrawal from activities
- ☐ Eating changes (eating more/less)
- ☐ Headaches
- ☐ Stomach aches/nausea
- ☐ Other body aches (please list):

  _____
- ☐ Trying to "be perfect"
- ☐ Ritualistic behavior/repetitive behaviors
- ☐ Other: _____

Faith/Spirituality

- ☐ Loss of faith or belief system
- ☐ Increase in faith

Other Reactions*

- ☐ Talk about hurting/killing oneself or others
- ☐ Attempting to hurt/kill oneself or others
- ☐ Cutting/self-harm acts
- ☐ Use of substances (e.g., drugs, alcohol, prescription drugs, etc.). Start of use and type of substance:

  _____
- ☐ Risky behavior (please explain):

  _____
- ☐ Preoccupation with death/dying

*Please speak with your counselor if you have identified risk for suicidal ideation or self-harm.

Specific concerns you have:

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