Transitions GriefCare
Formerly Horizons Grief Center

CHILD INTAKE FORM

Office Use Only
Name: _____
DOB: _____
DOS: _____

Child's Name: _____

Date of Birth: _____ **Today's Date:** _____

What is the child's preferred language? ○ English ○ Spanish ○ Chinese ○ Other:

Child Bereavement Information

What questions or concerns for this child brought you in for this visit?

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

General Temperament: ☐ Easygoing ☐ Slow to warm up ☐ Challenging ☐ Other _____

Hobbies/interests: _____

Strengths and what this child does well: _____

Are there any special needs that we should know about to better assist this child (e.g., developmental information, ADHD, learning disabilities)? Describe any serious illnesses, operations, and injuries since birth, with dates and outcomes.

Is this child currently receiving or have they received counseling services in the past? ○ Yes ○ No

If yes, please list the name of counselor and the focus and length of counseling:

_____

Is this child currently taking any medication? ○ Yes ○ No

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

Do you know or suspect that this child has attempted to hurt self or others and/or expressed suicidal or homicidal thoughts? ○ Yes ○ No

Please bring this form with you to your first appointment.

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Experience of the Death, Loss, and Change

Please share other losses this child has experienced (e.g., death of pets, divorce/separation, new school, house move, other trauma):

Was this child present at the time of death? ○Yes ○No

If yes, describe circumstances: _____

Who else was present at the time of death? _____

Did this child view the body? ○Yes ○No

If yes, describe circumstances and reaction of the child: _____

Did this child attend funeral/memorial service/graveside service? ○Yes ○No

If yes, describe their participation and reaction: _____

What are the beliefs of the child's religion/spirituality regarding death and/or life after death? Please describe if this child has expressed any thoughts or feelings about this.

Does this child express feelings about wanting or not wanting peers/friends to know about the death? ○Yes ○No If yes, what have they said? _____

What was this child's relationship like with the deceased (e.g., close, conflicted, and/or ways they spent time together)? _____

How openly does this child talk about their thoughts, feelings, or memories related to death of their loved one? ☐ Avoids sharing ☐ Shares when asked ☐ Occasionally ☐ Shares often

Grief/Coping Information

Overall, how do you feel this child is coping since the death of their loved one? On a scale of one to ten, select the number that best describes your views on how well they are coping.

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

How does this child most easily express their thoughts and feelings and/or cope with difficult feelings/ circumstances?

☐ Talking it out
☐ Journaling/writing
☐ Drawing
☐ Music
☐ Physical activity
☐ Sports
☐ Friends
☐ Faith
☐ Humor
☐ Other: _____

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Common Grief Reactions

Below is a list of common grief reactions in children and teens. Please check the changes that you've noticed in this child as a result of their loved one's illness or death.

School
- ☐ Disruptions in class
- ☐ Difficulty getting homework done
- ☐ Grades dropping
- ☐ Skipping/absences from school
- ☐ Anxiety about or unwillingness to go to school
- ☐ Other: _____

Family/Friends
- ☐ Frequent fighting with family/friends
- ☐ Withdrawal from family/friends
- ☐ Isolation
- ☐ Other: _____

Dreams
- ☐ Dreams about the deceased
- ☐ Dreams about death in general
- ☐ Recurring dreams
- ☐ Nightmares
- ☐ Other: _____

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

Fears/Worries
- ☐ Fear of the dark
- ☐ Fear of death
- ☐ Fear of parent or other family member dying
- ☐ Fear of new experiences
- ☐ Fear of loud noises
- ☐ Anxiety about parent leaving or being away from parent

Behaviors
- ☐ Daydreaming
- ☐ Decreased ability to concentrate
- ☐ Decreased energy level or feeling overly tired
- ☐ Withdrawal from activities
- ☐ Eating changes (eating more/less)
- ☐ Sleeping changes (trouble going to sleep, waking at night, sleeping too much)
- ☐ Unwillingness to sleep alone
- ☐ Headaches
- ☐ Stomach aches/nausea
- ☐ Other body aches (please list):

  _____
- ☐ Bed-wetting
- ☐ Thumb-sucking or baby talk
- ☐ Clinginess
- ☐ Trying to "be perfect"
- ☐ Talk about hurting/killing oneself or others*
- ☐ Attempting to hurt/kill oneself or others*
- ☐ Use of substances (e.g., drugs, alcohol, prescription drugs, etc.). Start of use and type of substance:

  _____
- ☐ Risky behavior (please explain):

  _____
- ☐ Talking about death/dying
- ☐ Refusing to talk about the deceased
- ☐ Ritualistic or repetitive behaviors
- ☐ Other: _____

*Please speak with a children's counselor if you know or suspect that this child has attempted to hurt self or others and/or expresses suicidal or homicidal thoughts.

Specific concerns you have: