"Grieving Through the Holidays" Registration Form

A. INDIVIDUAL INFORMATION

Name: _____

Address: _____

Phone: (H) _____ (C) _____ (Email) _____

Date of Birth: _____ Current Age: _____ Gender: _____

Names/Ages/Relationship of those living in your home:

_____

_____

_____

_____

In case of an emergency who should we contact? _____

How did you learn about Calvert Hospice Bereavement Services?

_____

B. BEREAVEMENT HISTORY

Name of Deceased/Relationship to you	Date of Death	Cause of Death	Age at Death

Was the deceased a patient of Calvert Hospice? ☐ Yes ☐ No

C. PHYSICAL AND EMOTIONAL STATUS: (Please check to indicate problem)

	Slight Problem	Moderate Problem	Severe Problem
Sleep Pattern	☐	☐	☐
Appetite	☐	☐	☐
Health Problems	☐	☐	☐
Weight Gain/Loss	☐	☐	☐
Concentration	☐	☐	☐
Interpersonal/Relationship Issues	☐	☐	☐

Feelings of Anxiety	☐	☐	☐
Feelings of Anger	☐	☐	☐
Feelings of Guilt	☐	☐	☐

☐Discusses loss	☐Angry	☐Anxious	☐In Denial	☐Depressed	☐Helpless
☐Avoids discussing loss	☐Guilty	☐Lonely	☐Numb	☐Relieved	☐Restless
☐Sad	☐Self-Reproachful		☐Tearful	☐Withdrawn	
☐Other:_____					

What seems to help you cope: _____

_____

_____

Current or prior counseling or therapy? ☐ Yes ☐ No