



“Til Death Do We Part: Spousal Loss Group” 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interpersonal/Relationship Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Sad Self-Reproachful Tearful Withdrawn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