"Understanding Your Grief" 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☐Sad ☐Self-Reproachful ☐Tearful ☐Withdrawn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