“Gone Without Me” Support Group Registration Form



1. INDIVIDUAL INFORMATION

Name: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone: (H) (C) (Email) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In case of an emergency who should we contact?

How did you learn about Calvert Hospice Bereavement Services?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **BEREAVEMENT HISTORY**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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Was the deceased a patient of Calvert Hospice? [ ]  Yes [ ]  No

1. **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| [ ] Sad [ ] Self-Reproachful [ ] Tearful [ ] Withdrawn  |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