“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| Sad Self-Reproachful Tearful Withdrawn | | | | |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