Angel House Bereavement Center

CLIENT INFORMATION FORM
CHILD AND ADOLESCENT
ID # _____

TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

CHILD'S PHONE _____ EMAIL _____

CURRENT SCHOOL _____ GRADES ATTENDED _____

PREVIOUS SCHOOL _____ GRADES ATTENDED _____

EXTRACURRICULAR ACTIVITIES _____

_____

SPECIAL EDUCATION NEEDS _____

_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME _____ OCCUPATION _____

ADDRESS _____
Street City State Zip

HOME PHONE _____ WORK PHONE _____ CELL _____

EMAIL _____ CUSTODY STATUS _____

PARENT/GUARDIAN NAME _____ OCCUPATION _____

ADDRESS _____
Street City State Zip

HOME PHONE _____ WORK PHONE _____ CELL _____

EMAIL _____ CUSTODY STATUS _____

EMERGENCY CONTACT _____ PHONE _____

How did you hear about Angel House Bereavement Center?

_____

Angel House
Bereavement Center

CLIENT INFORMATION FORM (2)
CHILD AND ADOLESCENT
ID #_____

Please answer the following questions so that we may better help your child.

What concerns or events have led you to seek services for your child at this time? _____

_____

_____

_____

_____

What other losses and/or significant life changes has your child experienced? This may include the death of loved ones, moving, school changes, relationship changes or loss, etc.

_____

_____

_____

_____

Do you expect to be or are you currently involved in/with:

☐ a lawsuit ☐ divorce proceedings

☐ law enforcement ☐ the Department of Children and Families

☐ a custody dispute ☐ court ordered counseling

Has your child had previous counseling and/or chemical dependency services? If yes, please list provider name(s), dates of service, purpose for services and whether or not counseling was helpful.

_____

_____

_____

Please list all persons living in your home, their age and relationship to your child, and any special circumstances related to them.

_____

_____

_____

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CLIENT INFORMATION FORM (3)
CHILD AND ADOLESCENT
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For each of the following areas please describe any changes you have noticed in your child.

- Relationship with parents/guardians _____

  _____

- School/grades/teachers _____

  _____

- Friendships/social life _____

  _____

- Sleeping/eating habits _____

  _____

- Participation in extracurricular activities (sports, music, dance, etc.) _____

  _____

Has your child complained of any physical symptoms (stomachaches, headaches, etc.)? _____

_____

_____

Please list your child's medical providers, medical problems and any current medications. _____

_____

_____

_____

Check all that apply to your child:

☐ makes friends easily, has an active social life
☐ has close friends that he/she can talk to
☐ has a supportive family
☐ is in special classes at school (gifted, developmentally delayed, honors, etc.)
☐ has been diagnosed with a mental illness
☐ has a physical, emotional or mental disability (please circle)
☐ has behavioral problems at home and/or school

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CLIENT INFORMATION FORM (4)
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Check all emotions that you believe your child is currently experiencing:

___ shock	___ hopelessness	___ embarrassment
___ guilt	___ withdrawal	___ confusion
___ fear	___ sadness	___ apathy
___ anger	___ loneliness	___ shame
___ relief	___ anxiety	___ helplessness

___ other _____

Please describe your child's typical daily routine. _____

_____

_____

Please describe any history of domestic violence, physical abuse, sexual abuse or neglect. _____

_____

_____

_____

What else would you like us to know about your child or your family? _____

_____

_____

_____