Angel House Bereavement Center

CLIENT INFORMATION FORM
ID # _____

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

PHONE _____ EMAIL _____

OCCUPATION _____ EMPLOYER _____

RELATIONSHIP STATUS: Single__ Married__ Partnered__ Divorced__ Widowed__ Separated __

EMERGENCY CONTACT _____ PHONE _____

How did you hear about Angel House Bereavement Center? _____

_____

Please answer the following questions so we can better understand your experience.

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

_____

_____

_____

What other losses and/or significant life changes have you experienced in the past five years? This may include death of loved ones, moving, job change or loss, relationship change or loss, etc.

_____

_____

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_____

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CLIENT INFORMATION FORM (2)
ID # _____

Please list all persons living in your home and any special concerns or problems they have.

_____

_____

_____

Have you experienced any health changes in the past five years? _____

_____

_____

What are your current medications and who is your primary care provider? _____

_____

_____

_____

Please list all of your hospitalizations, surgeries and dates of care (medical, psychiatric, chemical dependency, etc.)

_____

_____

_____

_____

Have you ever attempted suicide? Yes ___ No ___

Please circle the following conditions/problems you are currently experiencing:

Dizziness/fainting	Breathing difficulty	Unexplained pain/body aches
Rage	Nausea/vomiting	Frequent headaches
Tired most of the time	Irritability	Sleeping too little/too much
Indigestion/reflux	Difficulty concentrating	Shaking of hands, arms or legs
Chills, fever, night sweats	Over/under eating	Constipation/diarrhea
Mind racing	Chest tightness	Suicidal thoughts
Loss of interest in activities	Recent weight change	Jittery/nervousness
Outbursts of anger	Loss of the will to live	Feeling threatened
Blackouts/seizures	Violence in the home	Other: _____

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CLIENT INFORMATION FORM (3)
ID #_____

Do you or any of your family have addictive behaviors such as gambling, eating, shopping, sex, or excessive computer use? Yes _____ No _____ If yes, please explain each behavior: _____

_____

_____

_____

_____

Is there, or has there ever been, any substance abuse among any members of your household? Substances include but are not limited to alcohol, marijuana, cocaine, prescription drugs, and inhalants. Yes _____ No _____ If yes, please explain: _____

_____

_____

_____

_____

Have you ever been in a relationship where there was (check all that apply):

_____ physical violence?

_____ name calling or put downs?

_____ controlling or jealous behaviors?

_____ fear for your own safety or that of your children?

_____ none of the above

Have you had previous counseling and/or chemical dependency services? Yes _____ No_____

If yes, please list providers, dates of service and whether or not you felt the services were helpful.

_____

_____

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CLIENT INFORMATION FORM (4)
ID # _____

Is there anything else you would like us to know about you or your family? _____

_____

_____

_____

_____

What changes would you like to see as a result of counseling? _____

_____

_____

_____

_____