angel eyes

Child Loss Awareness

Children's Counseling Request Form

Angel Eyes is committed to supporting your child's grieving process in every way possible. We offer compassionate counseling services to all children impacted by the sudden, unexpected death of an infant or toddler. All services are conducted by an experienced bereavement counselor and provide children with the opportunity to explore and express their grief through art, play, writing, and other forms of sharing. We seek to create a safe and welcoming environment where children learn to cope with their loss and heal their pain.

Due to our limited resources we are only able to provide individual counseling services on a time-limited basis. Additionally, to provide services to as many families as possible, we are only able to provide counseling to individuals dealing with issues that are specifically grief-related. We understand that, often, other life issues intermix with grief. In those instances, we will refer to one of our excellent outside providers.

If your request is approved, your child will receive an initial 9 sessions. The frequency of these sessions will be determined by both client and grief counselor.

The following information is very important for us in providing the best service to your child. Please provide as accurate information as possible.

Date_____

Child's Name_____ Gender ❑ Male ❑ Female

Caregiver(s) Name _____

Address_____

Phone Number(s)_____ (home) _____ (cell)

Email _____

Child's Date of Birth_____

Name/Nicknames of Child Who Died_____

Relationship to Deceased Child _____

Date of Birth _____ Date of Death _____

Cause of Death _____

Please check the days of the week & specify the time of day that you are available for counseling, keeping in mind that Angel Eyes only sees clients Monday through Friday during normal business hours.

Day	Time/ Availability
❑ Monday	
❑ Tuesday	
❑ Wednesday	
❑ Thursday	
❑ Friday	

Frequency of counseling:

- ❑ Weekly
- ❑ Every other week

1. What are the reasons you are seeking counseling for your child?

2. When did these concerns begin?

3. Has s/he been in counseling before?

❑ Yes ❑ No

If yes, When _____ Duration _____ Where _____

Reason _____

Previous mental health diagnosis _____

4. Are s/he on medication?

❑ Yes ❑ No

If yes, please list the type of medication and the reason here:

5. To your knowledge, has s/he ever attempted suicide or self-harm in the past?

❑ Yes ❑ No

If yes, When_____Method _____

Due to the attempt, were you hospitalized? ❑ Yes ❑ No

If yes, When_____How long _____

Please explain:

6. Has s/he experienced or witnessed any violence at home?

❑ Yes ❑ No

If yes, please explain:

7. Has your child experienced any type of abuse (verbal, physical, emotional, sexual) or neglect?

❑ Yes ❑ No

If yes, please explain:

8. Does s/he or any other family member have any current involvement with the courts or correctional system?

❑ Yes ❑ No

If yes, please explain:

9. Current symptoms checklist (Mark all that apply).

Thinking

- ❑ Delusions (thought not based on reality)
- ❑ Hallucinations (seeing or hearing things)
- ❑ Disorganized speech (flight of ideas)
- ❑ Incoherent speech (mumbling, inaudible)

Relationships

- ❑ Parent/child issues
- ❑ Marital/ In-law issues
- ❑ Social/ Occupational

Substance/Drug Use

- ❑ Marijuana
- ❑ Cocaine
- ❑ Hallucinogens (LSD etc.)
- ❑ Meth
- ❑ Ecstasy
- ❑ Prescription
- ❑ Alcohol

Depression

- ❑ Sad most of the day
- ❑ Irritability/ Agitated
- ❑ Eating too much or too little
- ❑ Unable to sleep or too much
- ❑ Loss of interest
- ❑ Loss of energy
- ❑ Hopelessness
- ❑ Feeling of worthlessness
- ❑ Recurrent thoughts of death
- ❑ Thoughts of Suicide
- ❑ Attempted Suicide

Behaviors

- ❑ Hyperactive
- ❑ Disruptive
- ❑ Hostility directed toward authority figures
- ❑ Anger bursts
- ❑ Argumentative
- ❑ Blaming others for mistakes or misbehavior
- ❑ Aggressiveness toward family/ friends/ co-workers
- ❑ Difficulty maintaining friendships
- ❑ Refusal to comply
- ❑ Deliberately annoys other people
- ❑ Withdrawn from family members/ peers
- ❑ Occupational problems
- ❑ Refuse to go to take care of responsibilities
- ❑ Stealing
- ❑ Self – mutilation (cutting, burning, etc.)
- ❑ Eating disorder (Bulimia Nervosa, Anorexia Nervosa)
- ❑ Gang involvement

Anxiety

- ❑ Separation anxiety
- ❑ Constantly tense, worried, or "on edge"
- ❑ Restlessness
- ❑ Easily fatigued
- ❑ Difficulty concentrating
- ❑ Pounding heart
- ❑ Stomachache, headache or dizziness
- ❑ Frequent urination or diarrhea
- ❑ Shortness of breath
- ❑ Easily startled
- ❑ Nightmare or frightening dreams
- ❑ Fear of certain things

10. Please explain marked symptoms:

11. Is there anything else you believe would be helpful for us to know regarding your child?

If you have any questions throughout this process, please contact grief support coordinator, Rebecca, by phone or email.

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