



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 a licensed social worker 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 6 sessions**. The frequency of these sessions will be determined by both client and grief counselor. The necessity of providing additional sessions will be determined by client and counselor.

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

Child's Name: _____ Today's Date: _____
Child's Birthday: _____ Grade in School: _____

Race/Ethnicity: Asian Black/African White/Caucasian Hispanic/Latino
 Native American Other _____ Prefer not to answer

Caregiver(s) Name(s): _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
Phone Number: _____ E-mail: _____

Deceased Child's Name: _____ Relationship to Child: _____
Date of Birth: _____ Date of Death: _____
Cause of Death: _____

**Please check the days of the week & specify the time of day that
your child is available for counseling below:**

Days: Monday Tuesday Wednesday Thursday Friday

Time: _____

Frequency of counseling: Weekly Every Other Week

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

2. When did these concerns begin?

3. Has he/she been in counseling before?

Yes No

If yes, When: _____ Duration: _____

Where: _____

Reason:

Previous mental health diagnosis: _____

4. Is he/she currently on medication?

Yes No

If yes, what is the medication and reason for need

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

Yes No

If yes, When: _____ Method: _____

Due to the attempt, was your child hospitalized?

Yes No

If yes, When: _____ How long: _____

Please explain:

6. Has he/she ever 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 he/she or other family members have any current involvement with the courts or correctional system?

Yes No

If yes, please explain:

9. Current symptoms checklist

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
- 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
- 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 in order to most effectively work with your child?

If you have any questions, please feel free to contact Angel Eyes Bereavement Counselor,
Jamie Burke, LCSW
Please submit the forms to me via e-mail, fax, or mail.

Angel Eyes
ATTN: Jamie Burke
425 S Cherry Street, Suite 860
Denver, CO 80246

Phone: 303.320.7771
E-mail: jamie@angeleyes.org
Fax: 303.320.7827

Staff Only

Approved: Yes No

Approval Date: _____

If Yes, Assigned counselor: _____

If No, decline the reasons:

Referrals to:
