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## Adult Counseling Request Form

ANGEL EYES is committed to supporting your grieving process in every way possible. We have a licensed social worker on staff to provide individual counseling services to those who are impacted by the sudden, unexpected death of an infant or toddler and are seeking support in their grief process. Our goal is to provide space for adults to grieve and express themselves in ways that feel comfortable and safe.

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 individuals as possible, we can only provide counseling to those 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, you will receive an **initial 12 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 you. Please provide as accurate information as possible.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_

Race/Ethnicity:     Asian     Black/African     White/Caucasian     Hispanic/Latino

Native American     Other \_\_\_\_\_     Prefer not to answer

Name/Nicknames of Child Who Died: \_\_\_\_\_

Your 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 you are available for counseling.**

Days:  Monday  Tuesday  Wednesday  Thursday  Friday

Time: \_\_\_\_\_

**Frequency of counseling:**  Weekly  Every other week

**1. What are the reasons you would like to seek individual counseling? Do you have any major concerns for yourself or a family member?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. When did these concerns begin?** \_\_\_\_\_

\_\_\_\_\_

**3. Have you been in counseling before?**

Yes  No

If yes, When: \_\_\_\_\_ Duration: \_\_\_\_\_ Where: \_\_\_\_\_

Reason:

\_\_\_\_\_

**Previous mental health diagnosis:** \_\_\_\_\_

**4. Are you on medication?**

Yes  No

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Have you ever attempted suicide 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:

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6. Have you experienced or witnessed any violence at home?

- Yes       No

If yes, please explain:

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7. Have you experienced any type of abuse (verbal, physical, emotional, sexual) or neglect?

- Yes       No

If yes, please explain:

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8. Do you or other family members have any current involvement with the courts or correctional system?

- Yes       No

If yes, please explain:

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## 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
- 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

### 10. Please explain marked symptoms:

### 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

Thank you for taking the time to fill this form out.  
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**

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**Staff Only**

Approved:  Yes  No

Approval Date: \_\_\_\_\_

If Yes, Assigned counselor: \_\_\_\_\_

**If No, decline**

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**Referrals to:**

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