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:

____

____

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

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

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

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:

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,
Michael McAndrew MA LPC
Please submit the forms to me via e-mail, fax, or mail.

Angel Eyes
ATTN: Michael McAndrew
422 21st Street Units 4 & 5
Denver, CO 80205

Phone: **303.320.7771**
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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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