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

Angel Eyes
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Staff Only

Approved: ☐ **Yes** ☐ **No**

Approval Date: _____

If Yes, Assigned counselor: _____

If No, decline the reasons:

_____

_____

Referrals to:

_____

_____

_____