

Counseling Client Information



J. Worth Kilcrease, MBA, MA, LPC, FT

End-of-Life and Bereavement Counseling

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Part 1 - General Information

Name: _____ Age: _____ Date: _____

Address: _____

City: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Current status: Married Single Divorced Widowed In Relationship

The name of your spouse/significant other: _____

Please list all members of your immediate family (*Children/Step/Grand, Parents/Step, Grand, Siblings, etc.*), their ages, and a brief description of your relationship with each of them (*use the back of this page, if necessary*).

To whom do you go to for emotional support: _____

What is your religious/spiritual affiliation, if any: _____

Have you previously or are you presently receiving psychotherapy or counseling? Yes No

If yes, please list the time periods(s), the name and phone number of the therapist(s); the initial reasons(s) for therapy, how useful it was, any medications prescribed, and the reason for ending the relationship.

Please list any medications are you currently taking: _____

Unless you are bereaved, please go to Part 3 - Additional Information on Page 2.

Part 2 - Bereavement Information

What was/were the name(s), age(s), of the person(s) who died?

What was the person's relationship to you? _____

When did the person(s) die? _____

What were the circumstance(s)/cause(s) of the death(s)?

Have you had any previous losses and, if so, who and when?

Are you experiencing any of the following? *Check all that apply.*

Feelings

- | | | | |
|---------------------------------------|-------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Fear | <input type="checkbox"/> Anger | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Freedom | <input type="checkbox"/> Relief | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | | |

Thoughts

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Disbelief | <input type="checkbox"/> Confusion | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Preoccupation |
| <input type="checkbox"/> Harming Yourself | <input type="checkbox"/> Harming Others | <input type="checkbox"/> Unusual Happenings | |

Behaviors

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Dreams | <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Avoiding/Treasuring Reminders | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Searching/Calling Out |

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Part 3 - Additional Information

Please describe what is troubling you the most:

What else might be helpful for me to know about you?

How did you find out about my services?

Referred by _____ Internet website _____

Telephone Book Other _____