HOPE'S HOUSE

De Pere, Wisconsin

GRIEF SUPPORT ADULT INTAKE FORM

DATE: _____

NAME: (FIRST, M.I., LAST)_____

DATE OF BIRTH: (DD/MM/YY) _____ GENDER:_____

FAITH/RELIGION:_____ PHONE: _____

EMAIL: _____

HOME ADDRESS: _____

CURRENT HOUSEHOLD MEMBERS: (Check all that apply)

I LIVE ALONE ____ *I LIVE WITH MY SPOUSE* ____ *I LIVE WITH MY CHILD(REN)* ____

I LIVE WITH OTHER (please specify) _____

CHILDREN IN HOME:

Child 1 Full Name: _____ *Birth Date:*_____

Child 2 Full Name: _____ *Birth Date:*_____

Child 3 Full Name: _____ *Birth Date:*_____

Child 4 Full Name: _____ *Birth Date:*_____

*PET(S)?*_____

DECEASED PERSON'S NAME:

_____ AGE:_____

DATE OF DEATH: _____ RELATIONSHIP TO YOU: _____

CIRCUMSTANCES OF DEATH: _____

_____

_____

_____

OTHER LOSSES: _____

_____

_____

_____

WHAT SPECIAL CONCERNS DO YOU WANT TO ADDRESS THROUGH GRIEF SUPPORT SERVICES?

WHAT ARE YOUR GOALS? PLEASE BRIEFLY EXPLAIN: _____

_____

_____

_____

_____

_____

PLEASE **CHECK ALL** OF THE REACTIONS YOU ARE CURRENTLY EXPERIENCING:

___LONELINESS	___GUILT	___FEAR	___RELIEF
___EATING/SLEEP DISTURBANCE	___RESTLESSNESS	___FATIGUE	___ANXIETY
___NEGATIVE ATTITUDE	___HOPELESSNESS	___DEPRESSION	___ANGER
___LACK OF MOTIVATION	___JOYLESSNESS	___WORRYING	___ SHAME
___LOSS OF MEANING	___IRRITABILITY	___FORGETFULNESS	
___POOR CONCENTRATION	___FEELING FOGGY	___DOUBTING BELIEFS	
___SENSE OF ISOLATION	___SUICIDAL THOUGHTS OR IDEATION		
___MOOD SWINGS	___DIFFICULTY WITH OTHERS' REACTIONS		

___DIFFICULTY WITH THE WAY OTHERS ARE SHOWING OR NOT SHOWING THEIR GRIEF

DISCLAIMER: SERVICES PROVIDED BY HOPE'S HOUSE ARE NOT A SUBSTITUTE FOR MEDICAL ADVICE OR TREATMENT.

CONFIDENTIALITY: YOUR PERSONAL INFORMATION (AS ON THIS INTAKE FORM), AS WELL AS THE CONTENT OF YOUR SUPPORT SERVICES SESSIONS WITH A REPRESENTATIVE REPRESENTING HOPE'S HOUSE, MAY BE USED IN CASE OF AN EMERGENCY SITUATION ONLY. IN ORDER TO KEEP YOU AND THE COMMUNITY SAFE: WE OFFER CONFIDENTIALITY IN OUR SESSIONS. THIS MEANS WHATEVER YOU SAY IN A SUPPORT SESSION WE WILL NOT TELL OTHERS WITHOUT YOUR PERMISSION EXCEPT FOR THREE CONDITIONS:

1. *YOU HAVE A PLAN TO HARM YOURSELF OR SOMEONE ELSE. (THIS MEANS THAT YOU HAVE PLANNED OUT THE EXACT SITUATION WHERE SOMEONE CAN GET HURT, WE HAVE A DUTY TO REPORT THAT.)*
2. *YOU SHARE A PAST OR PRESENT CASE OF CHILD ABUSE THAT HAS NOT YET BEEN REPORTED.*
3. *WE GET COURT SUBPOENAED, WHICH MEANS THE COURT REQUESTS DOCUMENTS OF OUR SESSIONS WITH YOU.*

PHOTO RELEASE: WE REALLY ENJOY SHARING NEWS AND EVENTS TO PROMOTE HOPE'S HOUSE WITHIN THE COMMUNITY, HOWEVER YOUR PRIVACY IS VERY IMPORTANT TO US. PLEASE CHECK ONE AND SIGN IF APPROPRIATE:

____ Yes, Hope's House has my permission to use my and/or my child's photograph publically. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian's signature: _____Date_____

Parent/Guardian's Name:_____

Child(ren)'s Name: _____

____ No, Please do not use any of our photos to help promote Hope's House.

COMMUNICATION OF PRIVATE MENTAL HEALTH INFORMATION

*PLEASE **(V)** ALL ACCEPTABLE FORMS OF COMMUNICATION TO PROVIDE QUALITY CLIENT CARE:*

□ I AUTHORIZE HOPE'S HOUSE REPRESENTATIVES TO LEAVE A MESSAGE REGARDING MY PRIVATE INFORMATION ON MY PERSONAL …….VOICEMAIL/ANSWERING MACHINE.

□ I AUTHORIZE HOPE'S HOUSE REPRESENTATIVES TO SEND WRITTEN COMMUNICATION TO MY HOME OR EMAIL ADDRESS.

□ I AUTHORIZE HOPE'S HOUSE REPRESENTATIVES TO SHARE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS I MAY BE ASSOCIATED WITH, NOW OR IN THE FUTURE, IF HELPFUL TO MY CARE.

□ BY SIGNING BELOW, I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND HEREBY GIVE AUTHORIZATION FOR THE RELEASE OF INFORMATION BY THE ACCEPTABLE MEANS CHECKED ABOVE.

PAYMENT: ***THERE IS NO CHARGE FOR OUR SERVICES.***

SIGNED:_____ **DATE:** _____