

**Enrollment Form
For Individuals/Couples Requesting Services From
Michael's Place**

Today's Date _____

Your Name _____ Birthdate _____

Spouse/Partner Name, if applicable _____ Birthdate _____

Address _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Email address: _____

Would you like to receive our monthly calendar (via email)? _____ Yes _____ No

If you DO NOT have an email, we have our calendars available on our website and on site

How did you hear about us? If referred, please list source _____

Have you ever been convicted of criminal activity against a child? _____

If yes, please explain: _____

Who is the person who died? If more than one person, please list below.

Name: _____ Date of Birth: _____

Date of death: _____ Age: _____ Cause of death _____

Relationship to adult(s) above _____

Is there any additional information you think we should know? Please explain.

Demographics: (Optional—this information is used to help us obtain grants and other funding.)

Age Range: __18-24 __25-34 __35-44 __45-54 __55-64 __65 +

Race/Ethnicity: __American Indian / Native American __Asian __Black / African American

__Hispanic / Latino __White / Caucasian __Pacific Islander __Other

Religious Preference (please specify): _____

Household Income: __Under \$20,000 __ \$20,000- 29,999 __\$30,000-\$39,999 __\$40,000-\$49,000

__\$50,000+



1212 Veterans Drive
Traverse City, MI 49684
231.947.6453 Phone
231.947.7114 Fax
www.MyMichaelsPlace.net

Emergency Contact Information:

Emergency Contact Name: _____

Emergency Phone Number: _____

Relationship: _____

Self-Evaluation:

Many people describe grief as a journey. Please indicate by marking an “X” on the line below at the place that you believe best represents where you are at this moment in your journey today. (*See scale below for reference*)



(0) Just beginning (25) some distance (50) moderate distance (75) substantial distance (100) a long way

Evaluation Scale:

0: Struggle getting out of bed, brushing teeth, etc... (Basic functioning)

25: Struggle with missing work/school/ day to day activities/ sleep changes

50: Avoiding situations/places/people that remind you of your loved one; avoiding current relationships and/or building new relationships

75: Starting to rebuild relationships, engage in activities and interests/see hope

100: Adapted to the “new normal

**MICHAEL'S PLACE
MEDICAL INFORMATION**

Have you been treated by a doctor for a medical or psychological condition in the past 12 months? If yes, please explain.

Are you currently being seen by a counselor or therapist? If yes, please explain.

Are you taking any medications Michael's Place needs to be aware of? If yes, what?

Do you have any allergies we should know about? (foods, medications, bee sting, etc.)

**MICHAEL'S PLACE
FAMILY RELEASE FORM**

We understand that Michael's Place provides support and offers no therapy or counseling. Our family is here to share our experiences of loss, and to interact with others who are coping with the death of a family member or friend.

We understand that group discussion content, writing and artwork may sometimes be used for training, teaching and educating the public about the needs of grieving people and/or research. Michael's Place will always ask permission to share any piece. At no time will names of any participants be released without permission.

As participants at Michael's Place, we will respect the confidentiality of all information gained from all participants. We can also expect that what we share will be held in strict confidence by all facilitators and other participants. Sometimes information that we share in our groups will be shared with other facilitators if it will enable them to better understand the needs of our family members, but that information will be held in confidence.

I have read and understand the Michael's Place Policies and Important Information included in the Enrollment Packet.

Michael's Place has my permission to use pictures of myself and/or my family. ___ Yes ___ No

Signed: _____ Date: _____

For Office Use Only:

Date of Enrollment _____

Recommended Support
Group _____

Planned Start Date _____

Referral to Outside
Resources _____

Other Follow-Up
Needed _____

Notes: