

Couples Requesting Services
Enrollment Form

Today's Date: _____

Your Name: _____ Birthdate: _____

Spouse/Partner Name: _____ Birthdate: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Your Phone #: _____ Partner's Phone #: _____

Your Email Address: _____

Partner's Email Address: _____

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

**Our calendars are also available on our website and on-site at our front desk.*

How did you hear about us? Please list source: _____

Have you or your partner ever been convicted of criminal activity against a child? ___ Yes ___ No

If yes, please explain: _____

Who is the person who died? Please list below or additional in the notes section on the last page.

Name: _____ Date of Birth: _____

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

Relationship to adult(s) above: _____

Name: _____ Date of Birth: _____

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

Relationship to adult(s) above: _____

Name: _____ Date of Birth: _____

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

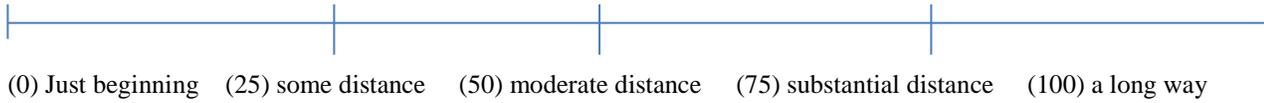
Relationship to adult(s) above: _____

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



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.



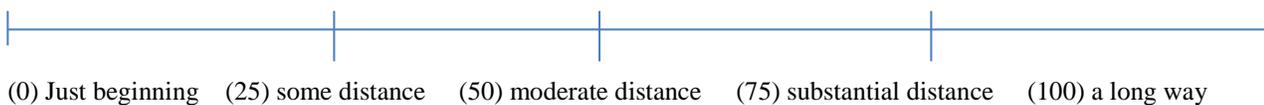
**Please answer the following questions based on how often they are true for you:
always true, sometimes true, never true.**

- | | | | |
|---|--------|-----------|-------|
| 1. I get the right amount of sleep per night. | always | sometimes | never |
| 3. I take care of my physical health through balanced nutrition, hydration, and movement. | always | sometimes | never |
| 3. My attendance and performance at work meets productivity expectations. | always | sometimes | never |
| 4. I feel I can ask for the help I need. | always | sometimes | never |
| 5. I feel a sense of belonging in my community. | always | sometimes | never |

Is there any other information you would like to share about your grief journey?

Partner's 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.



**Please answer the following questions based on how often they are true for you:
always true, sometimes true, never true.**

- | | | | |
|---|--------|-----------|-------|
| 1. I get the right amount of sleep per night. | always | sometimes | never |
| 3. I take care of my physical health through balanced nutrition, hydration, and movement. | always | sometimes | never |
| 3. My attendance and performance at work meets productivity expectations. | always | sometimes | never |
| 4. I feel I can ask for the help I need. | always | sometimes | never |
| 5. I feel a sense of belonging in my community. | always | sometimes | never |

Is there any other information you would like to share about your grief journey?

Emergency Contact Information:

Emergency Contact Name: _____

Emergency Phone Number: _____

Relationship: _____

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+

Marital Status: _____



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: