Michael's Place
let the healing begin

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.

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

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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.

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

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.

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

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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:_____

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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: