

Information Form

Today's Date: _____

Your Name: _____ Birthdate: _____

Spouse's Name, (if applicable): _____ Birthdate: _____

(Complete children's information on page 4)

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Your Phone #: _____ Spouse's Phone #, (if applicable): _____

Your Email Address: _____

Spouse's Email Address, (if applicable): _____

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

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.

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: ☐ White/Caucasian ☐ American Indian/Native American ☐ Asian
☐ Hispanic/Latino ☐ Black/African American ☐ Pacific Islander ☐ Other

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer not to disclose
☐ Other: _____

Household Income: ☐ Under \$20,000 ☐ \$20,000- 29,999 ☐ \$30,000-\$39,999
☐ \$40,000-\$49,000 ☐ \$50,000+

Religious Preference (please specify): _____

Place of Employment: _____

Marital Status: _____

Spouse's 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: ☐ White/Caucasian ☐ American Indian/Native American ☐ Asian
☐ Hispanic/Latino ☐ Black/African American ☐ Pacific Islander ☐ Other

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer not to disclose
☐ Other: _____

Place of Employment, (if applicable): _____

Children who services are being requested for, (if applicable):

Are you the parent or legal guardian of these children? _____ Yes _____ No

NAME (Include nickname) BIRTHDATE AGE SCHOOL GRADE GENDER

What have the children been told about the death?

Is there anything the children have **not** been told about the death?

What concerns do you have about each of the children and their grief work?

Have there been other changes or losses your family has experienced recently? (*moving, loss of job, new school, illness, divorce, other deaths, etc.*)

Do you or your children have any special needs or conditions we should be aware of? (*i.e. learning disabilities, allergies, etc.*)

Medical Information:

Do you have any medical or mental health concerns we should be aware of? If yes, please explain.

How often do you struggle with thoughts of suicide or self-harm? always sometimes never

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

Do you or any household members have any allergies we should be aware of? If yes, please explain.

Participation Agreement:

Please review and initial each line:

____ I confirm that no member of my household attending Michael's Place has been convicted of a crime against a child. *If not, please explain:*

____ I acknowledge that Michael's Place is not a counseling agency, but provides peer-to-peer support for grieving individuals and families.

Completion of this document does not guarantee access to Michael's Place programs and services.

By signing, I acknowledge, understand and commit to the agreement above.

Signed: _____ Date: _____

Spouse's Signature, (if applicable): _____ Date: _____