Michael's Place
let the healing begin

# Information Form

Today's Date:_____

Your Name:_____Birthdate:_____

*(Complete children's information on page 4)*

Spouse's Name, *(if applicable)*:_____Birthdate:_____

Address:_____City:_____

State:_____Zip:_____County:_____

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

Your Email Address: _____

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

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:_____

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.



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## *Emergency Contact Information:*

Emergency Contact Name: _____

Emergency Phone Number: _____

Relationship: _____

## *Your Self-Evaluation:*

Many people describe grief as a journey. What is your number between 0-100 on the line below at the place that you believe best represents where you are at this moment in your journey? _____

(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
2. 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
6. I struggle with thoughts of suicide or self-harm
   ☐ always ☐ sometimes ☐ never

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



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***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 ☐Hispanic/Latino ☐Black/African American ☐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:**_____

## *Spouse's Self-Evaluation, (if applicable):*

Many people describe grief as a journey. What is your number between 0-100 on the line below at the place that you believe best represents where you are at this moment in your journey? _____

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

NAME (Include nickname) BIRTHDATE AGE SCHOOL GRADE

_____

_____

_____

_____

_____

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

What have the children been told about the death?

What beliefs do the children have concerning what has happened to the person who died? *(Heaven, with the angels, spirit world, reincarnation, etc)*

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

Were the children involved in the funeral and burial?

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.)*



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## *MEDICAL INFORMATION:*

Have you or your spouse ever been convicted of criminal activity against a child? If yes, please explain.

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:

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

As participants at Michael's Place, we will respect the confidentiality of all information shared and expect that what is shared by other participants will be held in strict confidence. Information discussed in our groups may be shared in confidence with other facilitators to enable them to better understand the needs of our family members.

I understand that Michael's Place will ask permission to use any discussion content, writing, or artwork for the purpose of grief training, education, or research. At no time will names of any participant be released without permission.

I understand that Michael's Place follows the inclement weather policy of the Traverse City Area Public Schools and if the district is closed due to weather, our office will be closed and all in-person programming for that day will be cancelled.

I agree to not attend any Michael's Place programming if I or anyone in my household has felt unwell within the last 7 days.

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: