# Bridging The Gap

**A Hospice Program for Grieving Children**
**Sponsored by Peterson Hospice**
**An outreach of Peterson Regional Medical Center**

## Intake Questionnaire: Family Information

**Date** _____

## General Information

**Name(s) of parent(s) or guardian(s):**

_____

_____

**Address:** _____

_____

**City:** _____ **Zip:** _____

**Phones:** **home:** _____ **work:** _____

**Cell:** _____**Do you text?**_____

**E-mail:** _____

**CHILDREN:** **(PLACE A CHECK BY THOSE WHO WILL PARTICIPATE IN OUR GROUPS)**

| | **(PLEASE LIST FULL NAME)** | | **(BIRTH DATE)** |
|---|---|---|---|
| ☐ | _____ | M F | _____ |
| ☐ | _____ | M F | _____ |
| ☐ | _____ | M F | _____ |
| ☐ | _____ | M F | _____ |

**Family's religious preference: _____**

**Are there any special beliefs that we should know about?** _____

_____

# About the Deceased

**Name:** _____

**Relationship to children (e.g.: father, mother, sister, brother, grandfather, grandmother, aunt, uncle, friend, etc.):** _____

**Birth date (if known):** _____

**Death date:** _____ **Age:** _____

**Cause of death:** _____

**Death was:** ☐ **sudden** ☐ **lingering** ☐ **other**

**Have the children been told everything about the death?** ☐ **Yes** ☐ **No**

**If not, please explain:** _____

_____

**What kind of funeral & burial were chosen?** _____

_____

**Did the children attend?** ☐ **Yes** ☐ **No**

**If not, why not?** _____

**Has anyone else close to the children died?** ☐ **Yes** ☐ **No**

**If yes:**

**Name:** _____

**Relationship to children:** _____

**Birth date:** _____ **Death date:** _____ **Age:** ____

**Cause of death:** _____

**Death was:** ☐ **sudden** ☐ **lingering** ☐ **other**

***Use back side for multiple deaths***

**Have there been any other significant losses (divorce, moving, pet loss, etc.)?**

_____

_____

_____

## For Homicide Survivors Only:

***THE FOLLOWING INFORMATION WILL BE KEPT IN STRICTEST CONFIDENCE.***

**Name of suspect or defendant:** _____

☐ **Unknown**

**County where offense occurred:** _____

**Date of offense:** _____

**What has happened so far?** _____

_____

_____

## What other programs or therapy have you tried?

**(PLEASE CHECK ALL THAT APPLY)**

☐ School counselor
☐ Private counselor
☐ Psychiatrist
☐ Psychologist
☐ Pastoral counselor
☐ Other program(s):
_____
_____

## Who recommended that you come to Bridging The Gap?

**(PLEASE CHECK ALL THAT APPLY)**

☐ Therapist or counselor
☐ Teacher
☐ Doctor, nurse or other medical professional
☐ Clergy
☐ Friend or acquaintance
☐ Media
☐ Other:
_____

## Please give us any other information that will help us work with your children:

_____

_____

_____

_____

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**Intake Questionnaire: About Your Child**

***PLEASE FILL OUT A SEPARATE FORM FOR EACH CHILD!***

**Date** _____

**Child's Name:**_____ **Nickname:**_____

**Age:**_____ **Birthdate:**_____ **School Grade:**_____

**School attending:** _____

**Child's cell:**_____ **Does he/she text?**_____

**Child's Email:**_____

**T-shirt size:** **Adult: XL Lg Med Sm** **Youth: Lg Med Sm**

**Please describe this child's mental/emotional state:**

_____

_____

**How attached was this child to the deceased?**

| Extremely | More than normal | Normally attached | Less than normal | Hardly attached at all |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**How well has this child been able to express feelings?**

| Completely | Well | Average | Not so well | Not at all |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Is this child seeing a counselor?** ☐ **Yes** ☐ **No**

**If so, whom?** _____

**Is this child on medication?** ☐ **Yes** ☐ **No**

**If so, what?** _____