INTAKE FORM- Pet Grief

GENERAL INFORMATION

Name_____ **Date**_____ **Gender** M or F

Birth Date: _____ /_____ /_____ **Age:** _____

Address: _____

_____

Home Phone: ( ) **May we leave a message?** Yes No

Cell/Other Phone: ( ) **May we leave a message?** Yes No

E-mail: _____ **May we email you?** Yes No

Referred by (if any): _____

Married, Single, Divorced or Separated? _____

What was your pet name who past: _____

Male or Female **How long did you have your baby?** **_____**

Was the death of your pet sudden or anticipated? _____

Explain:

_____
_____
_____
_____
_____
_____

Do you have any other pets in your home? Yes or No

IF yes name(s), age(s) and breed:

_____

GENERAL HEALTH AND MENTAL HEALTH

Have you previously received any type of mental health services (psychotherapy, psychiatric Services, etc.)?

- o No
- o Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- o Yes
- o No
- o Please list: _____
  _____

Have you ever been prescribed psychiatric medication?

- o Yes
- o No
- o Please list and provide dates: _____

How would you rate your current physical health?

- o Poor
- o Unsatisfactory
- o Satisfactory
- o Good
- o Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits?

- o Poor
- o Unsatisfactory
- o Satisfactory
- o Good
- o Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

Please list any difficulties you experience with your appetite or eating patterns

_____

Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

If you have a history or currently experiencing major symptoms:

o Depression

o Anxiety

o General Sadness

o Mood Swings

o Obsessive Worries

o Panic Anxiety

o Times of Confusion

o Loss of Memory

o Drug Abuse

o Inattention/Hyperactivity

o Behavior Problems

o Relationships or Family Issues

o Other _____

Please check the major stressor(s) that preceded or accompanied your symptoms:

o Marital Issues

o Parent/Child Issues

o Job Issues

o Health Issues

o Trauma

o Increased Obligations/Responsibilities

o Significant Change

o Financial Issues

o Issues of the Past (guilt, abuse, family of origin)

o Other_____

o Difficult to identify

My symptoms began _____ (weeks or months) **ago and have been**

- increasing
- decreasing
- no change

Please describe your goals for therapy:

1._____

2._____

3._____

Please select any of the following that you have EVER experienced:

o Behavioral Problems

o Self-Mutilation (cutting etc.) (If so, when was last occurrence?)

o Eating Issues (Under or Overeating, Binging and Purging)

o Sexual Issues (addiction, performance anxiety, pornography)

o Legal Issues

o Severe Trauma

o Suicidal Thoughts If yes, when did you last experience such thoughts?

_____

FAMILY HISTORY

Have you experienced any other death within your family or circle of friends? If so who and how long ago?

_____

_____

_____

Did you have animals while growing up? Yes or No

Have you experienced death of a pet in the past if so, when, and name of your pet?

_____

_____

_____

Do you have children? IF so what are their names and ages:

_____

_____

_____

How are they doing with the loss of your pet?

In general would you describe your childhood and family of origin as:

o Pleasant

o Great

o Normal amount of fussing but generally good

o Abusive

o I have very little memory of my childhood

o I was mostly withdrawn from my family

o Dysfunctional

Any other information you feel would help with your session to understand your feelings:

Thank you!

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