

## Child-Specific Information

Child's Name: \_\_\_\_\_ Your Relationship to the Child \_\_\_\_\_

Today's Date: \_\_\_\_\_

	Death 1	Death 2	Death 3	Death 4
<b>Did the child witness the death?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Did the child attend the funeral?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>How close was the child to the person who died?</b>	<input type="checkbox"/> Not very close <input type="checkbox"/> Average <input type="checkbox"/> Very Close	<input type="checkbox"/> Not very close <input type="checkbox"/> Average <input type="checkbox"/> Very Close	<input type="checkbox"/> Not very close <input type="checkbox"/> Average <input type="checkbox"/> Very Close	<input type="checkbox"/> Not very close <input type="checkbox"/> Average <input type="checkbox"/> Very Close

### Had the child experienced any of the following before the death? (All that apply)

Physical Abuse  When: \_\_\_\_\_ Relationship to perpetrator: \_\_\_\_\_

Sexual Abuse  When: \_\_\_\_\_ Relationship to perpetrator: \_\_\_\_\_

Depression  When: \_\_\_\_\_

Anger/Aggression  When: \_\_\_\_\_

Problems in School  When: \_\_\_\_\_

Suicide Attempt(s)  When: \_\_\_\_\_

Addiction/Substance Abuse  When: \_\_\_\_\_

### School

Does your child receive any special assistance at school such as tutoring, advanced placement, or special classes? (Specify)

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Has the school environment been supportive of your child or have there been problems since the death? (Specify)

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**Reactions to Loss**

How does your child most easily express him- or herself (talking, writing, art, physical games)?

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What would you like the counselor to know about your child?

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**Relationships**

How would you describe your relationship with your child? How does your child relate with other family members?

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How would you describe your child's relationship with peers (Ages of peers, extrovert, introvert, leader, follower)?

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**Health**

Does your child have any health concerns? Any allergies? Any food allergies? Has he or she had any serious injuries or illnesses? Is your child taking any medications?

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What is your child's most frequent health problem?

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