formerly HospiceCare of Boulder & Broomfield Counties
COMMUNITYCARE
Hospice | Supportive Services

TRU
Trusted
Responsive
Unparal eled

Child/Teen Intake Care Plan

TRU Grief Services

Child or Teen's Name_____

Parent/Guardian Name_____

Address_____
Street City State Zip Code

Home Phone (___)_____

Work Phone (____)_____ May I contact you at work Yes_____ No_____

E-mail_____

Religious Affiliation/Faith Community, if applicable_____

Current relationship status: _____Single _____Married _____Divorced
_____Widowed _____Partnered _____Co-habitating

Please list all persons living in the home:

Name	Age	Date of birth	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently employed?_____Yes _____No

Current employer?_____Profession/Type of Work:_____

Information about the person(s) who died

Name of Person Who Died_____Relationship to child/teen_____

Date of Birth_____Date of Death_____Age_____

Cause of Death_____Place of death_____

Circumstances/Information about the death_____

_____

_____

What does your child/teen know about the death?_____

_____

Is there anything your child/teen does not know about the death? If so, what? _____

_____

_____

(If the illness was long-term) Please describe how your child participated in care during the dying process: ____

How would you describe you the kind of relationship your child/teen had with the person who died?

Was the person who died a TRU Community Care patient? Yes_____

Loss History, Support Systems, Coping

Has your child/teen or family experienced other significant losses (changing schools, divorce, jobs, pets, health other deaths)?

Are there other stressors for your child/teen or your family right now?

When you and/or your family have had a difficult time in your life in the past, how did you cope?

How is your child/teen coping now? Have you noticed changes in eating, sleeping, fears, grades, alcohol/drug use, etc?

What support does your child/teen have? (friends, family, church, community, school)

Have you noticed any changes (bedwetting, temper tantrums, withdrawn) in your child since the death (please describe behavior and expressing emotions)?

Has your child/teen or anyone in your family previously participated in counseling? Yes_____ No____

If yes, what were the circumstances:_____

_____

Is your child/teen or anyone in your family currently receiving mental health services Yes_____No___

Therapist Name_____ Phone_____

Has your child/teen or anyone in your family been diagnosed with a mental health diagnosis? Yes_____No___

If yes, please identify:_____

Has your child/teen or anyone in your family seriously considered or attempted suicide? Yes_____ No____

If yes, please explain:_____

Is your child/teen or anyone in your family taking any medications regularly? Yes____ No____

If yes, please list:_____

Has your child/teen or anyone in your family ever abused drugs or alcohol? Yes_ No____

Explain _____

Have any of the children in the family ever been abused (physical, sexual, verbal, emotional)? Yes____ No___

If yes, please describe the circumstances and follow-up taken: _____

_____

_____

Is your child/teen involved in any active or past cases (traffic, civil, criminal)? Yes_____ No____

If yes, please describe the circumstances and indicate any pending court and hearing/trial dates: _____

_____

_____

If you are divorced/separated/never married who has custody of your child/teen?_____

Custody status: Temporary____ Permanent____

If there is a joint custody arrangement, please describe (the legal decision maker is):

_____

Parent/Guardian Signature _____ Date _____

Services

My child/teen is interested in:

Groups_____

Individual or family counseling_____

Volunteering as a former healing circles participant_____

Participating in community events_____

Referrals to the community for support and services_____