Grief Evaluation for Children & Teenagers (17 and under)

MINOR'S NAME _____ Date of Session

COUNSELOR'S NAME Session Type ___Individual ____Group

Circle each symptom you have experienced since the loss/event or last session: Completed by ____ Parent ____ Minor

#	Statement of Symptoms	Never	Rarely	Sometimes	Often
1	Anger/Irritability	0	1	2	3
2	Crying	0	1	2	3
3	Sleep Disturbance	0	1	2	3
4	Problems Eating (over/under/binging/purging)	0	1	2	3
5	Withdrawing from Friends and Family	0	1	2	3
6	Afraid to Separate from Caregiver(s)	0	1	2	3
7	Suicidal Thoughts/Behaviors	0	1	2	3
8	Forgetfulness/Difficulty Concentrating/Distracted	0	1	2	3
9	Tiredness	0	1	2	3
10	Physical Issues (stomachaches, headaches, shakes)	0	1	2	3
11	Feeling Guilty/Responsible	0	1	2	3
12	Displaying Immature Behaviors	0	1	2	3
13	Aggressive Toward Others	0	1	2	3
14	Behavior Problems at School	0	1	2	3
15	Nightmares	0	1	2	3
16	Bedwetting/Toileting Accidents	0	1	2	3
17	Marked Worsening of Behavior	0	1	2	3
18	Behaving Destructively cutting, bullying, harming property	0	1	2	3
19	Behaving Compulsively	0	1	2	3
20	Hyperactive (Excessive Activity)	0	1	2	3
21	Easily Startled, Panic Attacks	0	1	2	3
22	School Grades Have Dropped	0	1	2	3
	POSITIVE READJUSTMENT TO EVERYDAY LIFE...	**Never**	**Rarely**	**Sometimes**	**Often**
1	Spending Time With Friends and Family	0	1	2	3
2	School Grades Have Improved	0	1	2	3
3	School Behavior Has Improved	0	1	2	3
4	Marked Improvement in Behavior	0	1	2	3
5	Smiling/Laughing	0	1	2	3
6	Feeling Hopeful About the Future	0	1	2	3
7	Participating in Usual Activities	0	1	2	3

_____ No medication changes since last visit
_____ No health changes since last visit

Changes:

I hereby authorize the release of any information necessary to process payment of this claim.

* **Signed: Parent/Guardian** _____