



# The Amelia Center

## Family Questionnaire

For office use only:

Date

Counselor

### Biographical Information

**Parent/Guardian/Self** (Please complete the following about yourself.)

**Name:** \_\_\_\_\_

**Date of Birth:**        /        / \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**County:**  Jefferson    Blount    Shelby    St. Clair    Walker  
 Other \_\_\_\_\_

**Email:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Spouse/Additional Guardian Information** (if applicable)

**Relationship:**  
(to you) \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date of Birth:**        /        / \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Address:**  
(if different from above) \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Emergency Contact**

**Name:** \_\_\_\_\_

**Relationship:**  
(to you) \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Demographic Information**

**Religious Affiliation:**

Protestant    Jewish    Catholic    Muslim    None    Other \_\_\_\_\_

**Place of Worship:** \_\_\_\_\_

**Annual Household Income:**    Under \$17,900                       \$17,901 to \$29,850

(Info. needed for funding purposes.)

\$29,851 to \$47,750                       over \$47,750

**How many people live in your household?** \_\_\_\_\_

**Family Members Attending Counseling**

<b><u>Full Name</u></b>	<b><u>Date of Birth</u></b>	<b><u>How is this person related to deceased?</u></b>
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

**Questions about Person who died**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_                      **Date of Death:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Cause of Death:**    Homicide    Car Accident    Suicide  
 Accidental Drug Overdose    Accident (specify) \_\_\_\_\_  
 Illness (specify) \_\_\_\_\_

*Approx. date of diagnosis of terminal illness:* \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Other information about the death:** \_\_\_\_\_

## ADDITIONAL LOSSES

### Questions about ADDITIONAL Person who died

**Name:** \_\_\_\_\_

**Date of Birth:**     /     /     **Date of Death:**     /     /

**Cause of Death:**    Homicide    Car Accident    Suicide  
                           Accidental Drug Overdose    Accident (specify) \_\_\_\_\_  
                           Illness (specify) \_\_\_\_\_

*Approx. date of diagnosis of terminal illness:* \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Other information about the death:** \_\_\_\_\_

**Please list any other deaths on the back of this page.**

### Other Losses Experienced

Death of pet:	<input type="checkbox"/>	Date of Loss:     /     /
Divorce:	<input type="checkbox"/>	Date of Loss:     /     /
Moving/loss of home:	<input type="checkbox"/>	Date of Loss:     /     /
School change:	<input type="checkbox"/>	Date of Loss:     /     /
Job change:	<input type="checkbox"/>	Date of Loss:     /     /
Loss of income:	<input type="checkbox"/>	Date of Loss:     /     /
Separation from family:	<input type="checkbox"/>	Date of Loss:     /     /

**How did you hear about The Amelia Center?** \_\_\_\_\_

As a client, you will begin receiving The Amelia Center newsletter, *Tears to Hope*, and email updates about group schedules and special events unless otherwise noted. If you do NOT wish to receive these communications, please mark the appropriate box:

I do NOT wish to receive The Amelia Center newsletter, *Tears to Hope*.

I do NOT wish to receive email updates about The Amelia Center group schedules and special events.