Annie's Hope
The Bereavement Center For Kids

TEEN SUPPORT GROUP
Enrollment Form

It is our mission to offer support to grieving families in a manner that is most beneficial for you. Because of this desire, we are asking you to complete this enrollment form as thoroughly as possible. Your answers are confidential. Thank you.

Your Name____ **Sex** M or F

Nickname, if any ____

Date of Birth _______ **Age** _______ **Age at the time of the loved one's death** _______

Grade in School _______ **Name of Your School** ____

Your Address____

City/State/Zip ____

Do you live within St. Louis City Limits? YES or NO. If not, in what county do you live?

____

Your Phone: (Home)____________________________ **(Work)** ______________________________

(Cell) ______________________ **Your E-Mail address:** ____________________________________

Parent/Guardian(s) Name	How is she/he related to you?	How is she/he related to the deceased?
______________________	________________________	_________________________________
______________________	________________________	_________________________________
______________________	________________________	_________________________________
______________________	________________________	_________________________________

Parent(s)/Guardian(s) Cell____

Parent(s)/Guardian(s) E-Mail address ____

Parent/Guardian's Place of Employment____

Is Your Address the Same as Your Parent(s)/Guardian(s)? ☐Yes ☐No

If Not, What is Their Address?

____

City/State/Zip ____

Phone: (Home)______________________ **(Work)**____

Please describe your personality/hobbies/talents:

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Names of brothers and sisters:	D.O.B	Age	Sex	Attending Support Groups?
________________________________	____	___	___	YES or NO
________________________________	____	___	___	YES or NO
________________________________	____	___	___	YES or NO
________________________________	____	___	___	YES or NO
________________________________	____	___	___	YES or NO

Background information on the deceased individual(s).

Full Name____

How is the deceased person related to you? She/He is my ________________________________.

Date of Birth __________ Date of Death __________

Former Place of Employment (if applicable):

____

Nature of the Death: please check all that are applicable

___ Short illness ___ Accident ___ Suicide ___ Cancer
___ Long illness ___ Murder ___ Heart Attack ___ Other

Please tell us the story of the death.

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Was an accurate, honest explanation of the death provided for you?
☐Yes ☐No
If not, what explanation was given to you?

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____

Is this the first experience with death for you? ☐Yes ☐No
If no, please briefly explain all losses by death:

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____

What other losses have you experienced? For ex. abandonment, divorce, moving, break up, jail time, etc.

Who told you about the loved one's death and how was it done? What was your reaction?

Please briefly state your religious affiliation, if any, and state what religious or spiritual beliefs were used to explain this death to you.

Did you get to say goodbye? ☐Yes ☐No
If yes, in what way?

Did you attend the funeral? ☐Yes ☐No

Did you plan or participate in the funeral/memorial service/shiva?
☐Yes ☐No
If yes, in what way?

Did you view the deceased? ☐Yes ☐No
If yes, what was your reaction?

Have you ever lost a pet through death? ☐Yes ☐No
If yes, what was your reaction and how was the death handled by other family members?

Have you shown any of the following behaviors since your experience with this death?
Please circle a number between 0 & 10 that equals how often the behavior occurs.
0 = never, 5 = sometimes, & 10 = very frequently

1.	afraid of the dark	0	1	2	3	4	5	6	7	8	9	10
2.	afraid to go to bed	0	1	2	3	4	5	6	7	8	9	10
3.	afraid of hospitals, physicians or their offices	0	1	2	3	4	5	6	7	8	9	10
4.	repeated illnesses	0	1	2	3	4	5	6	7	8	9	10
5.	clinging to parent or guardian	0	1	2	3	4	5	6	7	8	9	10
6.	changes in school work	0	1	2	3	4	5	6	7	8	9	10
7.	intense anger at self or others	0	1	2	3	4	5	6	7	8	9	10
8.	nightmares	0	1	2	3	4	5	6	7	8	9	10
9.	tantrums	0	1	2	3	4	5	6	7	8	9	10
10.	fighting	0	1	2	3	4	5	6	7	8	9	10
11.	hurtful behavior to self	0	1	2	3	4	5	6	7	8	9	10
12.	hurtful behavior to others	0	1	2	3	4	5	6	7	8	9	10
13.	destruction of property	0	1	2	3	4	5	6	7	8	9	10
14.	over or under eating	0	1	2	3	4	5	6	7	8	9	10
15.	bed wetting	0	1	2	3	4	5	6	7	8	9	10
16.	cruelty to animals	0	1	2	3	4	5	6	7	8	9	10
17.	withdrawal from family or friends	0	1	2	3	4	5	6	7	8	9	10
18.	obsession with death	0	1	2	3	4	5	6	7	8	9	10
19.	experimentation with sex	0	1	2	3	4	5	6	7	8	9	10
20.	use of drugs, alcohol or cigarettes	0	1	2	3	4	5	6	7	8	9	10
21.	difficulty concentrating	0	1	2	3	4	5	6	7	8	9	10
22.	oversleeping	0	1	2	3	4	5	6	7	8	9	10
23.	difficulty sleeping	0	1	2	3	4	5	6	7	8	9	10
24.	loss of appetite	0	1	2	3	4	5	6	7	8	9	10
25.	participation in risk-taking activities	0	1	2	3	4	5	6	7	8	9	10

Please add details about any of the behaviors listed above, especially, hurtful to self or others, destruction of property, cruelty to animals, use of drugs, alcohol or cigarettes, & fighting.

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Any recent changes of the members of the household other than the deceased? (separation, divorce, additional members, etc.)

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____
____

Any recent changes in environment? (move, new school, new job, caregivers, etc.)

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How have the responsibilities at home changed for you since the death occurred?

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Is there any additional information we should know?

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What do you hope to gain from attending the support groups?

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Have you ever received professional counseling? ☐Yes ☐No
When and with whom?

____
____
____

Do you take any medications for depression, anxiety, Bipolar Disease, Attention Deficit Hyperactivity Disorder (A.D.H.D.) or A.D.D.? ☐Yes ☐No
If yes, please list the medications below:

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Please share any social, emotional, physical or psychological struggles/challenges/limitations that you are experiencing now or in the past.

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Do you have any allergies? ☐Yes ☐No
If yes, please list below:

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____
____

Are you allergic or fearful of dogs? ☐Yes ☐No

Can you have snacks? ☐Yes ☐No

Do you have any dietary restrictions? ☐Yes ☐No

If yes, please list below:

____

____

____

Can you participate in outside activities? ☐Yes ☐No

To raise money for our programs, Annie's Hope applies for grant money from foundations and corporations. To do so, we need answers to the following questions. Please remember your answers are strictly confidential and optional.

Do you qualify for a free or reduced school lunch program? YES____ NO____ I DON'T KNOW ____

Does your family receive ADC, SSI (Supplemental Security Income) or Food Stamps? YES____ NO____
I DON'T KNOW ____

Do you belong to an organized religion? YES____ NO____
If so, please name the religion: ________________________________

Please check your race/ethnic background (check as many as needed):
African-American _____ Caucasian _____ Hispanic _____ Asian _____
Native American Indian _____ Other ______________________________

Do you have insurance coverage? YES____ NO____ I DON'T KNOW ____
If yes, -is it Medicaid? YES ____ NO ____ I DON'T KNOW____
Does it include mental health coverage? YES____ NO____ I DON'T KNOW ____

Who will be attending the adult sessions?

First & Last Name	How is she/he related to you?	How is she/he related to the deceased?

TEENAGERS SIGNATURE!! ____________________________ **Date** ______________

Signature of Parent/Guardian ____________________________ **Date** ______________

Signature of Director/Facilitator ____________________________ **Date** ______________

P.S. Please remember to include your parent/guardian's section.

PLEASE MAIL OR FAX THE COMPLETED FORMS BACK TO:

Annie's Hope
1333 W. Lockwood, Ste. 104
Glendale, MO 63122

314-918-1438 (Fax).
Annieshope.ali@gmail.com

For any questions or concerns, please contact Becky Byrne, Executive Director, or Ali Johnson, Program Director, at 314-965-5015 (Office) or Ali's cell at 217-419-2338.

REVISED 12-09-09

PHOTOGRAPHIC RELEASE

Teenager Group

In an effort to increase awareness in the community about Annie's Hope and to raise money to support our programs and services, we ask that you allow Annie's Hope staff or volunteers to take pictures of your child. The pictures may be used in our newsletter, on our web site, in our brochure, in slideshows, or in any other way that helps us to let the public know about Annie's Hope.

I, ___________________________________, hereby
parent/guardian

authorize ***Annie's Hope*** to take photographs, film, audiotapes, and

videotapes of my child, _____________________________________, and
teenager's name

to use them in newspapers, publications, and presentations.

Annie's Hope may use these such items and information in whatever way

the organization considers proper and desirable.

Date: _______________

Signature of parent or legal guardian:
____

Phone number: _____________________________

REVISED 8-10-06

STOP!
This page is for your parent/guardian to complete

Teenager's name: ____

Who is completing this form for the teen? ______________________________

How are you related to the deceased? ________________________________

Please describe your teen's personality/hobbies/talents:________________________

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In your opinion, has your teenager shown any of the following behaviors since his/her experience with this death?

Please circle a number between 0 & 10 that equals how often the behavior occurs.
0 = never, 5 = sometimes, & 10 = very frequently

1.	afraid of the dark	0	1	2	3	4	5	6	7	8	9	10
2.	afraid to go to bed	0	1	2	3	4	5	6	7	8	9	10
3.	afraid of hospitals, physicians or their offices	0	1	2	3	4	5	6	7	8	9	10
4.	repeated illnesses	0	1	2	3	4	5	6	7	8	9	10
5.	attachment to parent or guardian	0	1	2	3	4	5	6	7	8	9	10
6.	changes in school work	0	1	2	3	4	5	6	7	8	9	10
7.	intense anger	0	1	2	3	4	5	6	7	8	9	10
8.	nightmares	0	1	2	3	4	5	6	7	8	9	10
9.	overprotective behavior towards others	0	1	2	3	4	5	6	7	8	9	10
10.	fighting	0	1	2	3	4	5	6	7	8	9	10
11.	hurtful behavior to self	0	1	2	3	4	5	6	7	8	9	10
12.	hurtful behavior to others	0	1	2	3	4	5	6	7	8	9	10
13.	destruction of property	0	1	2	3	4	5	6	7	8	9	10
14.	over eating	0	1	2	3	4	5	6	7	8	9	10
15.	bed wetting	0	1	2	3	4	5	6	7	8	9	10
16.	cruelty to animals	0	1	2	3	4	5	6	7	8	9	10
17.	withdrawal from family or friends	0	1	2	3	4	5	6	7	8	9	10
18.	obsession with death	0	1	2	3	4	5	6	7	8	9	10
19.	change in sexual activity	0	1	2	3	4	5	6	7	8	9	10
20.	use of drugs, alcohol or cigarettes	0	1	2	3	4	5	6	7	8	9	10
21.	difficulty concentrating	0	1	2	3	4	5	6	7	8	9	10
22.	over sleeping	0	1	2	3	4	5	6	7	8	9	10
23.	difficulty sleeping	0	1	2	3	4	5	6	7	8	9	10
24.	loss of appetite	0	1	2	3	4	5	6	7	8	9	10
25.	participation in risk-taking activities	0	1	2	3	4	5	6	7	8	9	10

Please add details about any of the behaviors listed above, especially, hurtful to self or others, destruction of property, cruelty to animals, use of drugs, alcohol or cigarettes, changes in sexual activity, & fighting.

____

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If your teenager has a professional counselor/therapist, may we contact him/her to discuss your teen's needs? YES____ NO____ Name & Phone Number: ______________________