



Erika Nabuurs, Medicine Woman

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Merville, BC

DEATH/GRIEF INTAKE FORM

Patient Information

Name: _____ Age: _____

Address: _____

Phone: (H): _____ (C): _____

Email: _____

Estimated Death/Transition Date: _____

Please take a few slow, deep breaths, before you proceed to answer the following questions:

Are you the individual facing transition?

If so, how long have you felt/known that you may be dying?

Are you in search of grief support, due to the death of a loved one?

If so, how long have they been gone?

What emotions are you experiencing currently and/or recently?

How Frequently do these emotions arise? ex: weekly, daily, multiple times per day, constant?

How long do these emotions last? ex: seconds, minutes, hours, days, no reprieve?



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What is your relationship with these emotions?

ex: Do you welcome them; reject or escape from them; fear them; etc?

How are these emotions currently affecting your daily life?

How are you choosing to cope and/or navigate with these emotions?

Do you remember experiencing a period of shock initially? How long did it last?



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Did grief arise immediately, or was it delayed? If delayed, what was the recent event/thought/memory/dream that triggered the onset of grief?

Do you have any family or friends experiencing this loss with you?

Do you have anyone willing to support you - at least check in with you intermittently - as you walk through this journey of letting go?

Do you have any other concerns, questions, or comments you would like to share?

Signature

____/____/____
Date (Day/Month/Year)