



Compassionate Care Hospice Society (2016)

Youth Grief Program: Pre-Evaluation Form, Pre-K-Grade 3

Name: _____

Date: _____

Address _____

Whose idea was it to be here today?

Age: _____

Who are you grieving?

How long ago was your loss? _____

Where did you hear about this program? _____

Please circle the number that best describes you:

1. I have feelings of sadness

3. I feel angry for no reason

Yes No Sometimes

Yes No Sometimes

2. I have a hard time sleeping

4. I feel like I can laugh/ be happy

Yes No Sometimes

Yes No Sometimes

5. I know what "grief" is

6. I have people to talk to when I'm sad

Yes No Sort of

Yes No Sort of

8. I feel that I have a good understanding of my grief: **Yes No Sometimes**

9. I feel that I am comfortable talking about grief/ the person who has died: **Yes No Sometimes**

10. I feel like I know how to manage my grief in a healthy way: **Yes No Sometimes**