

**GROUP SCREENING FORM**

In order to help you address the concerns that brought you to the center, we sometimes recommend group counseling. We have found that group is often the most effective setting to help you meet your goals. Please fill out the top section of this form. Doing so does not necessarily mean group will be recommended for you.

Name: \_\_\_\_\_ Sex: M\_\_\_ F\_\_\_ Age: \_\_\_\_\_

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

Daytime Phone #: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

E-mail address \_\_\_\_\_

May we contact you at (*check those that apply*) \_\_\_day phone \_\_\_evening phone \_\_\_e-mail

# Credit Hours Enrolled \_\_\_\_\_

Please put an X through times not available:

	<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>
8am					
9am					
10 am					
11am					
12 noon					
1pm					
2pm					
3pm					
4pm					
5pm					
6pm					
7pm					

*FOR OFFICE USE: PLEASE DO NOT WRITE BELOW THIS LINE*

Intake Therapist \_\_\_\_\_ Assigned Therapist \_\_\_\_\_ Intake Date: \_\_\_\_\_

\_\_\_Group therapy indicated \_\_\_Unclear if group indicated \_\_\_Not group candidate at this time

\_\_\_Receptive to Group \_\_\_Some interest \_\_\_Interest at later date \_\_\_Not interested \_\_\_Didn't discuss

Reason for Referral to Group \_\_\_\_\_

**Contact Attempts**

Assigned to: \_\_\_\_\_

Date	Means	Outcome	Therapist Initials
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_____	_____	_____	_____
_____	_____	_____	_____

**Disposition**

Client Goals / Other Comments:

Will participate Yes \_\_\_ No \_\_\_