Group Intake Information

Date: ____________________

Name: ____ Group Name:____

Address: ____City__________________Zip______________

Date of Birth ____________________ Age______ School (if adolescent) ____

Primary Phone number :______________________________ ☐ Cell ☐ Home OK to leave msg? ☐Yes ☐No

Email address ____ OK for paperwork and/or correspondance? ☐Yes ☐No

1. Sex ☐ Male ☐ Female

2. Marital/Relationship Status
   - ☐ Single (never married)
   - ☐ Significant Other
   - ☐ Cohabitating (living together)
   - ☐ First Marriage
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Remarried (after divorce)
   - ☐ Remarried (after spouse's death)

3. Current Employment
   - ☐ Full-time
   - ☐ Part-time
   - ☐ Homemaker
   - ☐ Unemployed
   - ☐ Full-time student
   - ☐ Part-time student
   - ☐ Retired

4. Education
   - ☐ grade school/junior high
   - ☐ attending/attended high school
   - ☐ High school graduate
   - ☐ Attending/attended college
   - ☐ College graduate
   - ☐ Attending/attended graduate school
   - ☐ Technical school degree
   - ☐ Graduate degree (Masters)
   - ☐ Graduate degree (Doctoral)

5. Children in the house (include biological, adopted, foster, step, etc)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

6. Race/Ethnicity
   ☐ Caucasian ☐ Native American ☐ Latin or Spanish ☐Asian ☐African American ☐Multiracial ☐Other __________________

7. Language spoke in the home other than English ____

8. Primary Care Physician Info: (Name and Phone #)

____

If Currently under physician's care please indicate what for (and Physician's or Psychiatrist's name if different than PCP)

____

List current medications and amounts ____

____

Do you want us to coordinate care with your physician? ☐ Yes ☐ No

8. Please check any of the reasons listed below which resulted in your search for group therapy

- ☐ Depression or Anxiety
- ☐ Alcohol or other substance use
- ☐ Anger
- ☐ Thinking of harming self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Communication Difficulties
- ☐ Marital Problems
- ☐ Divorce/Blended families
- ☐ Parenting
- ☐ Low Self Esteem/self-worth
- ☐ Family conflict
- ☐ Difficulty with loss or death
- ☐ School learning difficulties
- ☐ Child Adjustment/parent conflict
- ☐ School Adjustment problems
- ☐ Intimacy
- ☐ Relationship Enhancement
- ☐ Pre-marital Counseling
- ☐ Sexual Orientation Questions
- ☐ ______________________________

9. Please explain what you are hoping to achieve with this group:

____
____
____

How would you know if things were getting better? ____
____
____

10. Are you currently in counseling or seeing a therapist for any specific issue? ☐ Yes ☐ No

Would you like us to coordinate your group counseling care with your provider? ☐ Yes ☐ No

Have you received prior counseling? ☐ Yes ☐ No

If yes, was it: Outpatient Inpatient
When:____________________________ Where: ______________________________________
Counselor/Doctor: ________________________________ Length of Treatment:____________________
Problem(s) treated: ____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse

11. How were you referred to group? ____

12. Person to contact in case of an emergency:

Name ____________________________________ Phone ________________________________

____ ____________________
Patient Signature Date