Group Therapy Registration Form
Outpatient Services
Bradley Hospital

Date Received:_____ MR#:_____

Groups will be filled on a first come, first served basis and children will be matched according to age and level of need.

Child's Name: _____ **Today's Date:** _____

Gender: ☐ male ☐ female Date of Birth: _____ Age: _____ Grade: _____

Insurance: _____

Name of Person Completing Form: _____ ☐ parent ☐ other: _____

Other parent/caregiver name(s):_____

Contact Home Phone #: _____ Cell Phone #: _____

Enrollment for:

☐ **iFriend** For children (8–11 years) with poor social development due to excessive rigidity, difficulty understanding other's point of view, and awkwardness/discomfort in social interactions.

☐ **T.A.G.** (Teen Anxiety Group**)** For teens (14-18 years) with excessive and persistent worry, physical symptoms related to stress, and who avoid situations, people, or places that cause distress.

☐ **Incredible Years** For parents of children (5-12 years) with disruptive, aggressive, and oppositional behaviors; learn strategies to increase your child's compliance, frustration tolerance, and social skills.

☐ **Mindful Teen** DBT-informed group for teens (13-18 years); designed to help teens learn to regulate emotions, tolerate distress, avoid self-destructive behaviors, and lead healthier lives.

☐ **Family Ties** For children (7-11 years) whose parents are going through a separation/divorce; promotes children's expression of feelings. Parents meet separately in a concurrent support group.

Why do you want your child or family to attend this group? _____

_____

_____

Does your child currently see a counselor, therapist, or psychiatrist? ☐ No

☐ Yes, counselor or therapist name: _____location:_____

☐ Yes, psychiatrist name: _____location:_____

Has your child ever been a patient at Bradley? ☐ no

☐ Yes, provider name(s): _____treatment dates:_____

Has your child ever been hospitalized or had residential treatment for psychiatric illness? ☐ no

☐ Yes, hospitalization location(s):_____dates:_____

☐ Yes, partial hospital/day treatment location(s):_____ dates:_____

☐ Yes, residential treatment location(s):_____dates:_____

Does your child require assistance in school for problems with: ☐ learning ☐ behavior ☐ IEP_____

Please describe: _____

Has your child ever repeated a grade? ☐ No ☐ yes, reason: _____

Medical Problems: ☐No ☐ Yes, describe: _____

Psychiatric Diagnoses: ☐ No ☐ Yes, describe: _____

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For Office Use Only:
Approved by: _____ date: _____
Child scheduled with: _____ date: _____ time: _____
Parent scheduled with: _____ date: _____ time: _____
Hold (reason): _____