# Group Therapy Pre-Screen Form 2026

By completing this form, you are giving your consent to provide personal information that will be used to assess your child's eligibility for group therapy. All information provided will be kept confidential and will only be shared with authorized members of the clinical team to ensure appropriate care. If you have concerns about confidentiality, please speak with the admissions coordinator or the therapist.

**Spots are limited, so please complete this pre-screen form as soon as possible.** Once you have completed the form, please email it to **support@teenswithtrauma.com**. One of our therapists will review the form and contact you to schedule your child's virtual intake session. This intake session will gather more detailed information and help determine if the group is a good fit, as well as what to expect moving forward.

**For questions, please contact us at support@teenswithtrauma.com or speak with your social worker.**

## Child/Teen Basic Information

**Name:**

**Date of Birth:**

**Gender:**

**School:**

**Your relationship to the teen:**

**Phone:**

**Email:**

**Referral Source:**

## Disclosure & Trauma History

**When and how was the trauma disclosed?**

**Can you describe the teen's current symptoms or experiences related to the trauma?**

**Has the teen had any contact with someone connected to their trauma?**

**Previous Diagnoses (if any):**

**Current Medications (if any):**

**Name of Psychiatrist (if applicable):**

## Mental Health & Therapy

**Is the teen currently or historically engaging in self-harming behaviors or experiencing suicidal thoughts?**

**Is the teen currently receiving services from other mental health providers?**

- ☐ Yes

Name of current therapist (if applicable):

- ☐ No
- ☐ Unsure

**Are you willing to allow us to connect with their provider for collaboration of care?**

- ☐ Yes
- ☐ No

**Readiness and Coping**

**In your opinion, is this teen ready to engage in discussions related to the trauma?**

**How does the teen typically interact with peers?**

**Given that group members may discuss difficult or triggering topics, how does the teen usually cope with emotional stress or overwhelm?**

**What supports are currently in place for the teen?**

## Symptoms

**Symptoms Checklist (check all that apply)**

- ☐ Nightmares
- ☐ Flashbacks
- ☐ Anxiety or Excessive Worry
- ☐ Somatic Symptoms (e.g., headaches, stomachaches)
- ☐ Ruminations (repetitive negative thoughts)
- ☐ Easily Frightened or Startled
- ☐ Difficulty Concentrating
- ☐ Avoidance of Certain Places/Situations
- ☐ Feeling Detached or Numb
- ☐ Irritability or Anger Outbursts
- ☐ Sadness or Frequent Tearfulness
- ☐ Difficulty Sleeping

## Substance Use Concerns (please answer to the best of your ability)

**Are you aware of the teen using any substances, including alcohol, recreational drugs, or prescription medications not prescribed to them?**

- ☐ Yes
- ☐ No
- ☐ Unsure

***If yes, please specify:***

**Have you ever had concerns about the teen's substance use?**

- ☐ Yes
- ☐ No
- ☐ Unsure

**Has the teen ever expressed or demonstrated using substances to cope with stress, emotions, or trauma-related symptoms?**

- ☐ Yes
- ☐ No
- ☐ Unsure

**Has any provider (school therapist, medical professional) expressed concern about potential substance use?**

- ☐ Yes
- ☐ No
- ☐ Unsure

**Suicidality & Safety Assessment**

**Has the teen ever expressed thoughts of suicide or self-harm?**

- ☐ Sí
- ☐ No
- ☐ No estoy seguro/a

***If yes, please provide any relevant context (when, how it was expressed, etc.):***

**Has the teen ever attempted suicide or engaged in self-harming behaviors (e.g., cutting, burning)?**

- ☐ Yes
- ☐ No
- ☐ Unsure

***If yes, please describe:***

**Are you currently concerned about the teen's safety due to suicidal thoughts, self-harm, or severe emotional distress?**

- ☐ Yes
- ☐ No
- ☐ Unsure

***If yes, please elaborate:***

**Has the teen ever been hospitalized or received crisis services due to safety concerns?**

- ☐ Yes
- ☐ No
- ☐ Unsure

***If yes, when and where (if known):***

## Risk Indicators (Based on Observations or Past Disclosures)

**Please indicate whether the teen has expressed or shown any of the following within the past few weeks:**

**Wishing they were dead:**

- ☐ Yes
- ☐ No
- ☐ Unsure

**Stating that their family would be better off without them:**

- ☐ Yes
- ☐ No
- ☐ Unsure

**Talking about or hinting at suicide:**

- ☐ Yes
- ☐ No
- ☐ Unsure

**History of suicide attempt(s):**

- ☐ Yes
- ☐ No
- ☐ Unsure

## Emergency Contact Information

**Name:**

**Relationship to the Teen:**

**Phone Number:**

## Additional Information

**Is there anything else you feel would be helpful for us to know?**