**Group Counseling Contract**

* Every member is expected to participate fully in the group process.
* For closed groups, members are expected to commit to the full length of the group, and attend all sessions.
* Members agree to not compare pain in any way and to be aware that each journey is different.
* Group members will be respectful in providing feedback to one another.
* Respectful and strict confidentiality is expected of all group members. All observed/communicated information (obtained formally/informally) is to be considered completely confidential-even if it seems public/unrelated to the group. Names of group members should also be kept confidential.
* While Touchstone Health Clinic requests strict confidentiality by group members, we cannot make guarantees about what individual group members will do. Each group member is responsible for deciding what information to share in the group setting.
* Group members who fail to abide by this contract, or who are deemed by counselors to be better served in another setting, will be referred to other services.
* Boundaries must be respected. Members are expected to receive permission before touching another participant.
* Group members having a difficult time in group are encouraged to check in and express feelings; if someone leaves group, they will answer missed group questions and process with the facilitator prior to returning to the group.
* Suicidal ideation/intent should be directed to the facilitator and not to other group members. If you acknowledge suicidal ideation and are a threat to self, then your counselor will have to contact someone in an attempt to support self-care.
* Additional information can be found in our HIPAA notice of privacy practices, clinic disclosure statement, and your counselor’s individual disclosure statement. You will be asked to sign all of the required forms. Failure to sign the forms will be noted, and Touchstone Health Clinic staff will continue to abide by the policies described within.

**I have read above guidelines and agree to abide by them.**

Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Checklist**

Please circle all of the symptoms you have experienced in the past two months:

Problems with relationships Parenting stressors

Feeling sad several days per week Excessive worry or nervousness

Major life changes Problems at work or school

Feeling “stressed out” Feeling lonely or isolated

Concerns about your alcohol/drug use Trouble sleeping

Lack of confidence Low self-esteem

Trouble making decisions Appetite changes

Difficulty relaxing Problems with anger

Feeling unmotivated Trouble concentrating

Feeling guilty or worthless Crying more often

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past two weeks, how many times have you had thoughts that you would be better off dead, or of hurting yourself?: (circle one)

Not at all Several days More than half the days Nearly every day

FOR COUNSELOR USE ONLY

Date reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: