



Group Therapy Case Note Template

Client Information			
First Name	Last Name	Date of Birth	Group
Note			
Group Topics Discussed			
Group Behavior Rating			
Seemed interested in the group	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Initiated positive interactions	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Shared emotions	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Helpful to others	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Disclosed information about self	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Understand group topics	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Showed listening skills/empathy	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Offered opinions/feedback	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Focused on group tasks	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Participated in group exercises	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Seemed to benefit from the session	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Treatment considerations addressed	<input type="checkbox"/> Strongly Disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Neutral <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree
Monthly Evaluation (Rate the Progress on the Following Topics)			
Participation	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Discussed Issues	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Insight	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Motivation	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Emotional Expression	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Stays on Task	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Objectives Being Met	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
		Suggestions	
		<input type="checkbox"/> Individual Counseling	
		<input type="checkbox"/> Evaluation for Medications	
		<input type="checkbox"/> Other, Please Specify:	
Individual Contributions This Session			
Therapist Name (Printed)	Therapist Signature 	Time Started	Time Finished
Co-therapist Name (Printed)	Co-therapist Signature 	Date	