Goodwin
Community Health

Goodwin Community Health
Anxiety Reduction Group Application

Date: _____

Name:_____ DOB:_____

Please confirm the following for our records:

Home Number: _____ Cell Number: _____

Address: _____ City: _____ State:____ Zip:_____

Why are you interested in the group: _____

_____

_____

Are you receiving mental health services at Goodwin: ☐Yes ☐No If yes, who is your provider?:

_____

Are you receiving mental health services at a different location: ☐Yes ☐No If yes, where or with whom?

_____

How long have you been experiencing anxiety: _____

In what ways does anxiety affect your life: _____

_____

_____

Have you ever been diagnosed with an anxiety disorder: ☐Yes ☐No If yes, please state when you were first diagnosed and if you recall a specific diagnosis: _____

Please return completed forms to Rima Sutton or the front desk or email rsutton@GoodwinCH.org

All applicants will receive follow up calls within one week regarding the group entry process.