GRAND OAKS
BEHAVIORAL HEALTH

Libertyville Office:
1800 Hollister Drive, Suite 201
Libertyville, IL 60048-5263

Northbrook Office:
3000 Dundee Road, Suite 111
Northbrook, IL 60062

ADULT INTAKE / INITIAL ASSESSMENT

Name _____ Date _____

Age _____ DOB _____ Gender _____ Race/Ethnicity _____ Marital Status _____

Occupation _____ PCP _____ Referred By _____

Please explain why you are currently seeking services at this time:

Briefly describe what your current coping strategies are:

Symptoms

Please check any of the symptoms that you are having or have had recently.

- ❑ Fatigue
- ❑ Stress
- ❑ Sadness/Depression
- ❑ Anger
- ❑ Worrying
- ❑ Memory Difficulties
- ❑ Low Energy
- ❑ Eating Behavior Issues
- ❑ Nervousness
- ❑ Social/Family Conflicts
- ❑ Mood Swings
- ❑ Low Self-Esteem
- ❑ Hopelessness
- ❑ Irritability
- ❑ Poor Concentration
- ❑ Anxiety
- ❑ Sleep Difficulties
- ❑ Perfectionism
- ❑ Sexual Difficulties
- ❑ Panic Attacks
- ❑ Hallucinations
- ❑ Suicidal Thoughts
- ❑ Muscle Tension
- ❑ Intrusive Thoughts
- ❑ Dizziness
- ❑ Weight Change
- ❑ Violent Behavior
- ❑ Loneliness/Isolation
- ❑ Speech Difficulties
- ❑ Physical Pain
- ❑ Work Difficulties
- ❑ Poor Judgment
- ❑ Obsessive/Compulsive
- ❑ Chest Pain
- ❑ Elevated Mood
- ❑ Nightmares
- ❑ Impulsiveness
- ❑ Feeling Worthless
- ❑ Excessive Sweating
- ❑ Body Image Concerns
- ❑ Heart Palpitations
- ❑ Sick Often
- ❑ Avoiding People
- ❑ Headaches
- ❑ Easily Distracted
- ❑ Disorganized Thoughts
- ❑ Trembling
- ❑ Thoughts of Harming Others

Phone: (847) 549-1189 • Fax: (847) 932-4066 • Website: www.grandoaksbh.com

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Symptoms – continued

Please add any useful details about your checked items.

Mental Health History

Please indicate if you had counseling/therapy in the past. If yes, then how effective was your previous experience?

Please indicate if you have taken any psychotropic medications. If yes, which medications and how would you describe the effectiveness of the medications?

Have you been hospitalized for mental health concerns (when, where, how long, & why)?

Please indicate if there has been any suicidal ideation or attempts at suicide? If yes, what was the post-treatment received?

Please describe your history with substance use?

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Background Information

Please explain if there are any legal circumstances and describe what that entails:

Please specify your current employment and any gaps in your employment history:

Please indicate your highest level of schooling completed high school, college, etc.)

Medical

Please describe any current medical problems:

Please describe any past medical problems:

Please list all medications that are currently being taken:

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Psychosocial History

Briefly describe your cultural / ethnic/ racial / religious background:

Please describe your family of origin (description of your childhood and structure of your family):

Please describe your current family structure (single, married, separated, divorced, children, all people living in the house):

Please indicate any known family psychiatric/mental health history:

Please indicate any known family history with substance use:

Please indicate any known traumatic events and/or abuse in your history:

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Psychosocial History, continued

Please describe your current and past relationship history:

Please describe your social support system:

Please indicate what are your recreational/preferred activities:

What are your goals for therapy? What would you like to accomplish?

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