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:

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Briefly describe what your current coping strategies are:

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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.

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Mental Health History

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

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

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

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

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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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