Glenview Counseling Group, LLC
3633 W. Lake Ave.
Suite 105
Glenview, IL 60026
(847)699-2490

Intake Assessment

To be completed by client only

Client's Name: _____ Date of Birth: _____

Age: _____ Sex: M / F Marital Status: _____

Address: _____

City/State: _____ Zip: _____

Referral Name: _____

Precipitating Factors

In general terms, why are you seeking counseling at this time:_____

_____

_____

_____

_____

_____

Treatment History:

Outpatient:_____

Inpatient:_____

Current or Recent General Symptoms

(Please circle)

Appetite Change	Loss of Interest	Frequent Anger
Disturbed Sleep	Self Injurious Behavior	Lying
Despondent	Illegal Behaviors	Isolation
Hopeless	Tearful	Motivation Loss
Truancy	Sad	Feelings of Guilt
Damaging Property	Mood Swings	Physical Complaints
Bullying/Fighting	Impulsivity	School Problems
Cruel to Animals	Increased Energy	Racing Thoughts
School Anxiety	No Energy	Relationship Problems
Impaired Social Ability	Poor Judgement	Restless
Hyperactive/ADHD	School Refusal	Rebellious
Suicidal Thoughts	Homicidal Thoughts	Suicidal Attempts

Other: _____

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Current or Recent Anxiety or OCD Symptoms

(Please Circle)

Restless	Panic Attacks	Obsessions	Unable to Function
Fears	Paranoid/Suspicious	Worrying	Ruminating
Cleanliness	Orderliness	Avoiding	Hair Pulling
Skin Picking	Impulses/Tics	Counting	Reassurance Seeking
Checking	Repeating	Washing	Hoarding
Thought Spinning	Trauma Flashbacks	Other: _____	

Current or Recent Other Symptoms

Disoriented/Confused	Hallucinations	Delusions
Aggression/Hostility	Severe Paranoia	Disorganized Thoughts
Disorganized Speech	Racing Thoughts	False Beliefs
Excited Behaviors	Memory Impairment	Wandering

Other: _____

Any current or past eating disorder behaviors: _____

_____

Any current or past substance abuse behaviors: _____

_____

_____

Current Withdrawal Symptoms: _____

Current Medical Conditions & Allergies:_____

_____

_____

Current Medications

Medication name and dosage: _____ Prescribing MD: _____

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Relationship Status

(Please Circle)

Single Married Partnered Separated Divorced Widowed Other: _____

Relationship satisfaction: _____

_____

Current Household

Please list the names, ages and relationships of the people living in your home:

Name	Age	Relationship	Comments

Current or Recent Employment

Job title or function: _____ Company: _____

How symptoms have interfered with employment responsibilities: _____

_____

_____

Current or Recent Education

Name of school: _____ Year or grade: _____

How symptoms have interfered with school responsibilities: _____

_____

_____

Spirituality and Faith

Do you identify with a religion or faith? Y / N If so, which religion or faith? _____

How have symptoms affected or been affected by religion or faith? _____

_____

Signed: _____ Date: _____

Witness: _____ Date: _____