3285 N Arlington Heights Rd
Suite 201
Arlington Heights, IL 60004

Family Resilience Group
3285 N Arlington Heights Rd Suite 201
Arlington heights IL 60004-1564
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1. Intake Assessment - Adult

Welcome to the Family Resilience Group!
In order to best know and help you, please complete the questions below. We want this to be your most effective and comfortable experience in counseling. If you are filling out this form on behalf of a minor, please answer the questions to the best of your ability for the person that will be attending therapy. Finally, please let our team know if you need any special accommodations or are unhappy with your results at any time. We're glad you're here!

If you are filling out this form for a minor, please answer the questions to the best of your ability for the person that will be attending therapy.

Date:

Name:

D.O.B:

Age:

Living Situation and, if applicable, who else is living in the home?:

How did you hear about The Family Resilience Group? If referral please provide name:

Gender assigned at Birth: Male / Female:

Gender Identity: Male / Female / Nonbinary:

Preferred pronouns:

How would you describe your sexual orientation?:

Are there any groups/cultures you identify with that would be important for your therapist to be aware of:

What brings you to therapy at this point?:

Have you had therapy before? If so, how was the experience?:

What would you like to accomplish in therapy? List 3 goals:

List your top difficulties/challenges in your life right now:

What medications/supplements are you taking?:

Do you exercise? If so what do you do, how often and for how long?:

Do you have a spiritual practice? If so, please describe:

How many days of the week do you consume alcohol? Please write typical frequency in a week and # of drinks per day:

Do you use recreational drugs? If yes, please describe type and frequency:

Please describe your current eating habits/challenges:

Typical breakfast:

Typical lunch:

Typical dinner:

Typical snacks:

How many hours of sleep do you get on average? Describe any challenges with falling asleep, staying asleep, nightmares, etc:

Risk Factors

Have you ever experienced thoughts of wanting to die? Y / N:

If yes, when and how frequent were thoughts?:

Have you ever had urges to self-harm? Y / N:

Have you ever acted on urges to self-harm? Y / N:

Do you have a history of disordered eating patterns such as restriction of calories, excessive dieting, bingeing and/or purging or other?:

How would you describe your relationship with your body?:

What is your occupation?:

Do you enjoy your work? Describe why or why not:

What kind of support system do you have? Please describe:

What are the BEST things in your life right now?:

Developmental History

In the following sections, please describe any traumatic experiences (i.e. accidents, medical procedures, surgeries, physical abuse, emotion abuse, sexual abuse or assault, experiences of breathing difficulty, motor vehicle accidents, relational/developmental trauma, birth or prenatal trauma if known, deaths, natural disaster involvement, war or military, trans-generational/historic, other.)

Please note: If you need to skip a section, you may opt to leave blank for now and give more details to your therapist in session.

Describe your life from 0-5 years of age:

Describe your life from 5-12 years of age:

Describe your life from 12-18 years of age:

Describe your life from 18-30 years of age:

Describe your life from 30-present years of age:

Is there anything else you would like your clinician to know about you?: