



407-906-0139

Intake@nolimitempowerment.org

ADULT INTAKE FORM

Please fill out this form, answer the questions below, and bring it to your initial session.
Please note: Information you provide here is protected as confidential information.

Name: _____ Today's Date: _____
(Last) (First) (Middle Initial)

Address: _____
(Building Number and Street) (City) (State) (Zip)

Home phone: (____) _____ May we leave a message Yes No

Cell/Other phone: (____) _____ May we leave a message? Yes No

E-mail*: _____ May we e-mail you? Yes No

*Please Note: E-mail correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

What is the relationship of person filling out this form to Client? _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____

Home: (____) _____ Cell/Other: (____) _____

2. Name: _____ Relationship: _____

Home: (____) _____ Cell/Other: (____) _____

I give No Limit Health and Edu , Inc.permission to contact the above emergency contacts for emergency reasons.

Initials _____

DEMOGRAPHICS

Birth date: _____ Age: _____ Gender: _____

Sexual Orientation: Heterosexual Gay Lesbian Bisexual Androgynous Questioning
 Prefer not to answer

Preferred Pronouns: He/Him/His She/Her/Hers They/Them/Theirs Other: _____

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Ethnic Background: _____

Languages: _____

Physical Disabilities: Wheelchair/Walker use Deaf/Hearing Difficulties since birth Deaf/Hearing Difficulties due to accident/age
 Problems with Sigh Other: _____ N/A

GENERAL AND MENTAL HEALTH INFORMATION

1. What is the reason you are seeking therapy? (Please describe precipitating event(s), current symptoms and impairments in life functioning, including when the problem started and how often you experience symptoms).

2. Have you previously received any type of mental health services (psychotherapy, psychiatric services, school counselor, hospitalizations due to mental health, etc.)?

No Yes, previous therapist/practitioner:

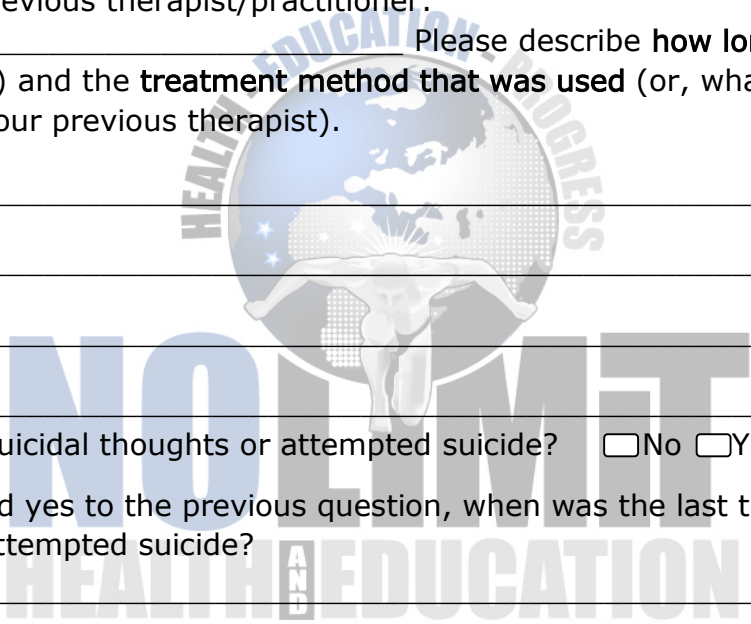
Please describe **how long were seen, diagnosis** (if any) and the **treatment method that was used** (or, what you liked, or disliked, about your previous therapist).

3. Have you ever had suicidal thoughts or attempted suicide? No Yes

3a. If you marked yes to the previous question, when was the last time you had suicidal thought or attempted suicide?

4. Have you ever been hospitalized for your suicidal thoughts, aggressive behavior, homicidal thoughts, or access to lethal means? No Yes

4a. If you marked yes to the previous question, please list the date(s), location(s) of hospitalization, and what caused the events to occur: _____



GENERAL AND MENTAL HEALTH INFORMATION (Continued)

5. Have you ever engaged in self harm behaviors or rituals? No Yes

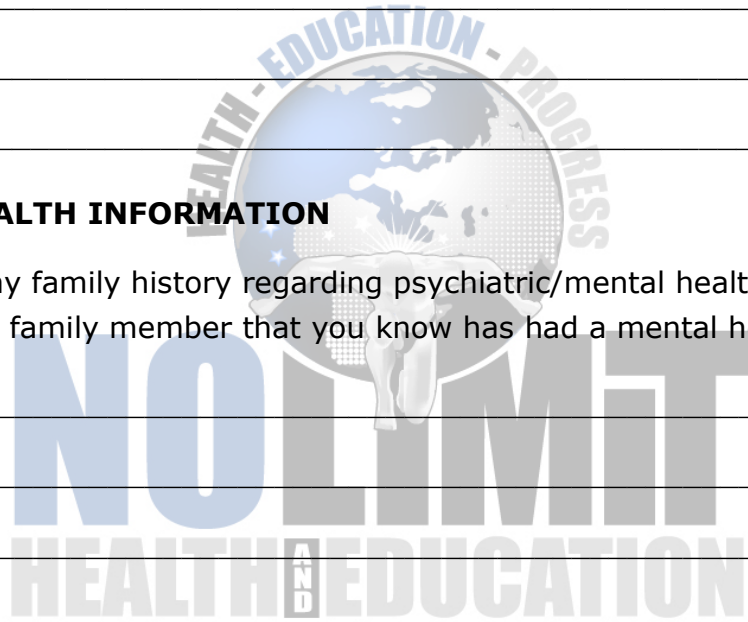
5a. If you marked yes to the previous question, please list the type of self-harm you engage in, or have engaged in, when it began, and any additional comments:

6. Have you ever had any trauma related experiences? No Yes

6a. If you marked yes to the previous question, please describe the trauma that you are comfortable sharing and/or discussing (nature of trauma, when it occurred, persons involved, and impact on ability to function).

FAMILY MENTAL HEALTH INFORMATION

7. Are you aware of any family history regarding psychiatric/mental health?
(Please list any family member that you know has had a mental health diagnosis)



8. Has anyone in your family ever committed suicide or attempted suicide? No Yes

8a. If you marked yes to the previous question, please list who committed or attempted suicide that you feel comfortable discussing.

FAMILY MENTAL HEALTH INFORMATION (Continued)

In the section below, please indicate if there is any family history of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, sibling, etc.).

	Please check	List family member
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Substance abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mania	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obsessive compulsive behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Auditory/Visual hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Domestic violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

MEDICAL CONDITIONS AND HISTORY

9. How would you rate your current physical health? (Please check one of the boxes below)

- Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific health problems you are currently experiencing:

10. Have you ever had a serious past health issue that is no longer a problem? No Yes

11. If known, when was the date of your last medical physical? _____

12. How would you rate your current sleeping habits? (Please check one of the boxes below)

- Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems you are currently experiencing:

13. How many times per week do you generally exercise?: _____

14. What types of exercise do you participate in?: _____

MEDICAL CONDITIONS AND HISTORY (Continued)

15. Please list any eating difficulties you have with your appetite or eating patterns:

16. Do you have any of the following types of allergies (Please list in the space provided if yes)

- Drug(s) Food Contact Animal Seasonal Other None

17. Have you ever been diagnosed with any developmental delays as a child? No Yes

17a. If Yes, please list the diagnosis: _____

BEHAVIOR CHECKLIST. Please check any of the following that concern you and/or those around you (Family, Friends, Co-Workers):

Behavior:	Current	Past	N/A	Behavior:	Current	Past	N/A
Sadness, crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of enjoyment of usual activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disobedient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prefer to be alone or social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm or injuring self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Identity concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low self-worth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias or fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trauma flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight or appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive worry or overly concerned about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling panicky, anxious, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with authority or the law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequently acting without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble finishing things or disorganized thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration/easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

MEDICATIONS AND SUBSTANCE USE

18. Are you currently taking, or have taken, any prescription psychiatric medication?

No Yes

18a. If you answered yes to the question above, please list as much information about your medication as you know (Medication, Dosage, Purpose, Doctor)

19. Do you drink alcohol more than once a week?

No Yes

19a. If Yes, how much and how often?

20. How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

FAMILY HISTORY

21. Are or were your parents married? No Yes

22. Are or were your parents divorced? No Yes

23. Were you adopted? If so, what age? No Yes Age: _____

24. Do you have stepparents? No Yes

25. Have any parents or siblings died? No Yes

25a. If so, indicate **name, cause of death, and when they died:**

26. Are you currently in a romantic relationship? No Yes

26a. If yes, for how long? _____

26b. Are you satisfied in your romantic relationship? No Yes

26c. If you answered No, what issues are present in the relationship?

27. Please list any children and their age: _____

FAMILY HISTORY (Continued)

28. Do you have any siblings? (Please list names and ages): _____

29. Please describe the quality of your relationships with your family members, as best you can:

SOCIAL, EDUCATIONAL, CAREER & PERSONAL HISTORY

30. What is your current living situation (Where do you live and with whom)?

31. Do you consider yourself to be spiritual or religious? No Yes

31a. If Yes, please describe your faith or belief:

32. Do you have any significant friendships? Please describe

33. Are you currently employed? No Yes

33a. If yes, what is your current employment situation (position/title & length at current place of employment): _____

33b. Do you enjoy your work? Is there anything stressful about your current work?

34. What is the highest level of education have you completed? _____

35. Please list any professional certifications, degrees or apprenticeships you have completed:

36. Have you ever been arrested? No Yes

36a. If Yes, please list when you were arrested, charges & convictions brought against you.

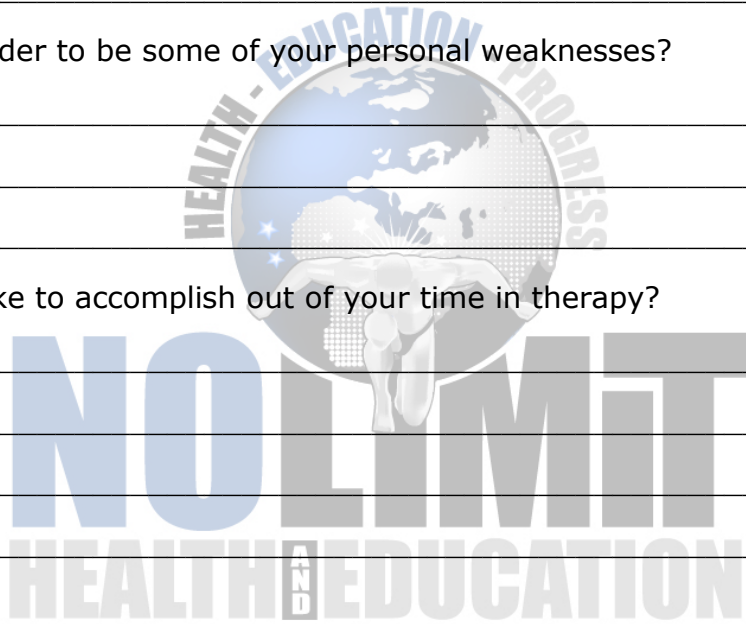
SOCIAL, EDUCATIONAL, CAREER & PERSONAL HISTORY (Continued)

37. Are there any additional significant life changes or stressful events that have happened recently that has impacted your ability to adequately function?

38. What do you consider to be some of your personal strengths?

39. What do you consider to be some of your personal weaknesses?

40. What would you like to accomplish out of your time in therapy?



Additional Notes: _____

Availability: _____

Therapist Signature

Date