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.perrmission to contact the above emergency contacts for emergency reasons.

Initials _____

DEMOGRAPHICS

Birth date: _____ Age: _____ Gender: _____

Sexual Orientation: ☐ Heterosexual ☐ G ay ☐ Lesbian ☐ Bisexual ☐ Androgynous ☐ Questioning ☐ Prefer not to answer

Preferred Pronouns: ◯ He/Him/His ◯ She/Her/Hers ◯ They/Them/Theirs ◯ Other_____

Marital Status: ◯ Single ◯ M arried ◯ 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	◯ Yes | ◯ No	_____
Substance abuse	◯ Yes | ◯ No	_____
Anxiety	◯ Yes | ◯ No	_____
Depression	◯ Yes | ◯ No	_____
Mania	◯ Yes | ◯ No	_____
Eating Disorder	◯ Yes | ◯ No	_____
Obesity	◯ Yes | ◯ No	_____
Obsessive compulsive behavior	◯ Yes | ◯ No	_____
Auditory/Visual hallucinations	◯ Yes | ◯ No	_____
Suicide attempts	◯ Yes | ◯ No	_____
Trauma	◯ Yes | ◯ No	_____
Domestic violence	◯ Yes | ◯ 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)

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Withdrawn	◯	◯	◯	Weight or appetite changes	◯	◯	◯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

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