407-906-0139 Intake@nolimitempowerment.org

ADOLESCENT 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

Your Cell 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 Education, Inc. to contact the above emergency contacts for emergency reasons
Initials _____

DEMOGRAPHICS

Birth date:_____Age:_____Gender: _____

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Androgynous
☐ Polyamorous ☐ Questioning ☐Prefer Not to Say

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

Ethnic Background: _____

Languages: _____

Physical Disabilities: ☐ Wheelchair User ☐ Deaf/Hearing Difficulties Since Birth

☐ Deaf/Hearing Difficulties Due to Age/Accident ☐ Problems W/Sight ☐ 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

   3.1 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

   4.1 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

5.1 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

6.1 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

8.1 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 ☐ Very Good
   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 ☐ Very Good
    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

_____

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

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Withdrawn	☐	☐	Mood swings	☐	☐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

MEDICATIONS AND SUBSTANCE USE

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

☐ No ☐ Yes

18.1 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 ☐ If yes, how much? _____

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

☐ Daily ☐ Weekly ☐ Month ☐ 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

If so, indicate name, cause of death, and when they died:

_____

_____

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

If yes, for how long?_____

26.1 Are you satisfied in your romantic relationship? ☐ No ☐ Yes

26.2 If you answered no, what issues are present in the relationship?

_____

_____

_____

FAMILY HISTORY (Continued)

27. Do you have any siblings? (please list names and ages): _____

_____

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

_____

_____

_____

_____

SOCIAL, EDUCATIONAL, CAREER & PERSONAL HISTORY

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

_____

_____

_____

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

30.1 If yes, please describe your faith or belief: _____

31. Do you have any significant friendships: _____

_____

32. Are you currently employed? ☐ No ☐ Yes

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

32.2 Do you enjoy your work? Is there anything stressful about your current work?

_____

33. What school do you currently attend and what grade level are you in?

School: _____ Grade: _____

34. How are your grades in school? _____

35. What do you enjoy about school? _____

36. What do you dislike about school? _____

SOCIAL, EDUCATIONAL, CAREER & PERSONAL HISTORY (Continued)

37. Have you have ever been arrested? ☐ No ☐ Yes

    37.1 If yes, please list when you were arrested, charges & convictions brought against you.

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

_____

Additional Notes:

Availability:

_____ _____

Therapist Signature Date