2121 S. Hiawassee Road, Suite 4663, Orlando, FL 32835
Phone: 321.465.9411 | Fax: 1.321.406.1426 |
Email: kevin.hardwick@lmfti.com | Website: www.lmfti.com

PARTICIPANT STRENGTHS & CHALLENGES

Please assist your therapist in getting to know you by identifying important strengths and challenges. Please note: information you provide here is protected as confidential information. We thank you in advance for filling out this form and bringing it to your first session.

Name:_____
(Last) (First) (Middle)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle)

Birth Date:__/____/____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Cell Phone: (____)_____ May we leave a message? □ Yes □ No

Alternate Phone: (____)_____ May we leave a message? □ Yes □ No

E-mail:_____ May we email you? □ Yes □ No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Referred by (if applicable): _____

LAMPEIN
Marriage and Family Therapy Institute, Inc

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PRIOR PSCYCHOTHERAPY/MEDICATION MANAGMENT

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes If yes, please indicate previous therapist(s)/practitioner(s): _____

_____

Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list: _____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please check)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing: _____

_____

_____

2. How would you rate your current sleeping habits? (please check)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing: _____

_____

_____

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

What types of exercise to you participate in? _____

_____

_____

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4. Please list any difficulties you experience with your appetite or eating patterns: _____
_____
_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No
If yes, when did you begin experiencing this? _____
_____

7. Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please describe: _____
_____

8. Do you drink alcohol more than once a week? □ Yes □ No If yes, please describe: ____
_____

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____ On a scale of 1-10 where 10 is the highest, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____
_____
_____
_____
_____

12. Please describe any unresolved family issues related to adoption or child/ren in out of home placement?
_____
_____
_____
_____

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13. Please describe any unresolved family issues related to blended family (step-family) involving children from prior relationships? Also, include financial, emotional, or behavioral challenges related to ex-partners?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

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

Behavioral Health Challenges:	**Please Check**	**List Family Member**
Alcohol/Substance Abuse	□ Yes □ No	
Anxiety	□ Yes □ No	
Autism Spectrum Disorder	□ Yes □ No	
Depression	□ Yes □ No	
Bi-Polar Disorder	□ Yes □ No	
Domestic Violence	□ Yes □ No	
Eating Disorders	□ Yes □ No	
Gambling Disorders	□ Yes □ No	
Hoarding	□ Yes □ No	
Incarceration	□ Yes □ No	
Neurological Impairment (e.g., Memory, Seizures, etc.)	□ Yes □ No	
Obesity	□ Yes □ No	
Obsessive Compulsive Behavior	□ Yes □ No	
Post-Traumatic Stress Disorder (PTSD)	□ Yes □ No	
Schizophrenia/Psychotic Disorders	□ Yes □ No	
Self-Injury (e.g. cutting, burning, risk taking behaviors, etc.)	□ Yes □ No	
Sexual Abuse	□ Yes □ No	
Suicide Attempts	□ Yes □ No	
Other:	□ Yes □ No	

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ADDITIONAL INFORMATION:

14. Are you currently employed? □ Yes □ No If yes, please describe challenges related to you/your family's current employment situation? _____

_____

_____

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

_____

_____

_____

15. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

18. What would you like to accomplish during your time in therapy?

_____

_____

_____

_____