LIFE HISTORY QUESTIONNAIRE

Client's Name: _____ Birth Date: _____
Today's Date: _____

Gender: ☐ male ☐ female ☐ Other _____ Age: _____ Ethnicity/Race: _____

Height: _____ Weight: _____ Corrective Lenses? _____ Hearing Aid? _____

Client's address: _____ Home Phone: _____
_____ Cell Phone: _____
Work Phone: _____

I give my permission to be called at: Home: ☐ yes ☐ no
Work: ☐ yes ☐ no
Cell: ☐ yes ☐ no

I understand that if I have caller ID, the counselor's name will be disclosed to others. _____ (Please initial)

Email: _____ May I email you? ☐ yes ☐ no

I understand that email might not be confidential. _____ (Please initial)

Best time and way to reach you _____

If an emergency arises and I need to reach someone close to you, whom should I call?

#1 Name:_____ Phone: _____

Relationship: _____

#2 Friend or relative not residing with you

Name: _____ Phone: _____

Relationship: _____

Chief Concern: Please briefly describe the issue(s) that brought you to counseling. And what concerns you the most right now: _____

_____

_____

_____

_____

_____

When did this start to be a concern? _____

Who referred you to this clinic? _____

☐ Physician ☐ Social Worker ☐ Therapist ☐ other _____

Please check any of the concerns that apply or have applied to you:

( ) Chronic sadness	( ) Crying episodes	( ) Hopelessness
( ) Difficulty concentrating	( ) Loss of appetite	( ) Overeating
( ) Nausea/Vomiting	( ) Difficulty making decisions	( ) Low energy/fatigue
( ) Agitation	( ) Restlessness	( ) Excessive worry
( ) Fearfulness	( ) Trembling/shaking	( ) Flashbacks
( ) Fear of loss of control	( ) Nightmares	( ) Fear of dying
( ) Intrusive thoughts/memories	( ) Easily startled	( ) Frequent forgetfulness
( ) Fears others talking about me	( ) Difficulty focusing	( ) Legal Problems
( ) Difficulty completing tasks	( ) Tendency to act impulsively	( ) Not well organized
( ) Difficulty at work	( ) Racing thoughts	( ) Excessive spending
( ) Excessive gambling	( ) Aggressive towards others	( ) Tried to kill myself
( ) Irritability	( ) Difficulty functioning socially	( ) Sleep problems
( ) Memory problems	( ) Thoughts of suicide	( ) Panic attacks
( ) Withdrawing from others	( ) Difficulty functioning at work	( ) Shortness of breath
( ) Reduced interest in activities	( ) Fear of leaving home	( ) Avoidance of public places
( ) Avoidance of social situations	( ) Pounding heart/palpitations	( ) Obsessive thoughts
( ) Feeling detached from others	( ) Self harm behavior	( ) Frequent headaches
( ) Sexual Concerns/Difficulties	( ) Multiple sexual partners	( ) Past physical/sexual abuse
( ) Alcohol/Substance abuse	( ) Problems with co-workers	( ) Marital conflict
( ) Hard to stay with a job long	( ) Seeing things others don't see	( ) Problems with school
( ) Taking on too many tasks	( ) Staying up for days without sleep	
( ) Hear voices others do not hear	( ) Infertility	( ) Recent Health Issues
( ) Concerns with parenting	( ) Fearful someone is plotting against me	
( ) Thoughts of physically hurting others	( ) OTHER_____	

Relationship Satisfaction

What is your romantic relationship status? ☐ Married ☐Separated ☐Divorced ☐Single ☐Engaged ☐Remarried ☐Widowed ☐Partnered/Significant Other ☐Cohabiting ☐Beginning New Relationship

If you are in a relationship please rate it in the following areas, on a scale of 1-10 (10 being most satisfied):

Communication ____	Conflict Management ____	Sex & Physical Intimacy ____
Finances____	Life / Work Balance ____	Spirituality & Religiosity ____
Parenting ____	Outside Support ____	Household Duties ____
Social Life (As Couple) ____	Social Life (As Individual) ____	Gender Roles ____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

Personal Qualities

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your areas for greatest improvement? _____

_____

_____

What would you like to accomplish during our meetings? _____

_____

_____

Family Background:

Spouse's Name (if applicable): _____ Date of marriage: _____

Age: _____ Occupation: _____

Highest Grade Completed: _____ Ethnicity/Race: _____

Other Individuals Living in Family Home:

Age	Gender	First Name	Relationship (daughter, son, grandparent, etc.)

Are your parents still living? ☐ Yes ☐ No

Mother's Name: _____ Age: _____

Occupation: _____ City/State of Residence: _____

Father Name: _____ Age: _____

Occupation: _____ City/State of Residence: _____

Please list your brothers and sisters:

Age	Gender	First Name	Relationship (brother, sister, step-sister, step-brother)

Medical History:

Physician's name: _____

Clinic and address: _____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

_____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?_____

_____

_____

Please list any hospitalizations, serious illnesses, or surgeries that you have had and indicate age:

_____

_____

_____

_____

_____

Which hand do you use for writing or drawing? ☐ Right ☐ Left

Are you currently on medications? ☐ Yes ☐ No (if yes, please indicate below type and dosage)

Name of medication	Dosage	Date first prescribed	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been prescribed psychiatric medications in the past? ☐ No ☐ Yes

Please list and provide dates: _____

_____

_____

Have you received previous counseling/psychological testing services? ☐ No ☐ Yes

If so, what did you find helpful?_____

Please describe these services below:

Type of services and concern	**Provider/Facility**	**Dates of Service**

Is there any history of the following problems? If yes, please describe.

- ☐ Learning difficulties: _____
- ☐ Speech difficulties_____
- ☐ Fever greater than 105°F_____
- ☐ Allergies/asthma _____
- ☐ Eating problems _____
- ☐ Deficits in motor skills _____
- ☐ Head injuries/loss of consciousness _____
- ☐ Seizures _____
- ☐ Hearing problems _____
- ☐ Vision problems _____

Have you experienced any of the following?

- ☐ Physical abuse _____
- ☐ Sexual abuse _____
- ☐ Verbal/emotional abuse _____
- ☐ Exposure to domestic violence abuse _____

Are you involved in any legal issues? _____

_____

_____

Family history of mental health problems (for example, depression, learning difficulties, ADHD, anxiety, alcoholism, mental retardation, schizophrenia, bipolar disorder, etc.): _____

_____

_____

_____

_____

_____

Education History:

High School: _____ GPA: _____

College: _____ Year Graduated: _____ Major: _____

Graduate School: _____ Year Graduated: _____ Major: _____

Did you ever receive special education services: ☐Yes ☐ No If yes, when? _____

Work History:

Are you currently employed? ☐No ☐Yes

Who is your current employer? _____

What is your position? _____

Prior Employment History:

Dates of Employment	Employer	Job Title/Duties

Alcohol/Drug Use:

Describe your current use of alcohol or non-prescription drugs: _____

_____

When did you first begin to use alcohol/non-prescription drugs (if applicable): _____

Have you ever received treatment for chemical use? _____

Lifestyle Habits:

Do you have any sleep difficulties? _____

What is your current use of caffeine? _____

What time do you go to bed? _____

How long does it usually take for you to fall asleep? _____

Do you wake during the night? _____

How many hours of sleep do you typically get at night? _____

How many hours per day do you use electronic devices and what type of media do you use? _____

_____

Additional Comments: