

LIFE HISTORY QUESTIONNAIRE PART I

Basic Information

Name:					
	First	Middle Initial	Last		
Address:					
	Street	Apt.	City	State	Zip
Date of Birth:	/	/	Age:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone (Cell):			Phone (Home):		
Phone (Work):			Occupation:		
Last grade of school completed:					
Past/Present Marital Status	Single:		Married since:		
	Separated since:		Divorced since:		
	Widowed since:		Dating Period:		
Children	NAMES		Ages	NAMES	
If I could change anything about myself or my situation it would be:					
1.					
2.					
3.					
4.					
5.					

Spiritual History

What value do you put on the Spiritual aspect of your life?

Individual Information

Circle the following that you believe portray or describe you:

A nobody	Controlling	Giving	Nervous	Ugly
Aggressive	Coward	Happy	Optimistic	Unforgiving
Alone	Critical	Inadequate	Passive	Unloved
Anxious	Deceitful	Inferior	Peaceful	Unstable
Argumentative	Depressed	Insecure	Proud	Useless
Attractive	Destructive	Intelligent	Saint	Worthwhile
Bitter	Disappointed	Introverted	Shy	Worthless
Bossy	Egotistical	Jealous	Sinner	
Calm	Empathetic	Kind	Spiteful	
Christian	Extroverted	Lazy	Stubborn	
Confident	Fearful	Misunderstood	Stupid	
Content	Friendly	Naive	Suicidal	

Circle all of the following that apply to your current condition:

Headaches	Don't like weekends	Take sedatives	Lonely	Take drugs
Palpitations	Don't like vacations	Feel panicky	Often use painkillers	Inferiority feelings
Bowel disturbances	Can't keep a job	Conflict	Fainting spells	Difficulty concentrating
Anger	Memory problems	Suicidal ideas	Anxiety	Overly ambitious
Nightmares	Financial problems	Sexual problems	No appetite	Excessive sweating
Feel Tense	Dizziness	Can't make decisions	Insomnia	Cannot have a good time
Depressed	Stomach trouble	Shy with people	Alcoholism	
Unable to relax	Fatigue	Can't make friends	Tremors	

Present interests and hobbies: _____

Clinical Information

State in your own words the nature of your main problems and their duration: _____

Give a brief account of the history and development of your complaint: _____

By circling one of the options below, please estimate the severity of your problem:

Mildly upsetting · Moderately upsetting · Very severe · Extremely Severe · Completely incapacitating

Whom have you previously consulted about your present problem? _____

Are you taking any medications? If yes, what, how much, and with what results? _____

LIFE HISTORY QUESTIONNAIRE PART II

Name:		Date:	
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Family History

Who were you raised by? Biological parents Step parents Grandparents
 Adopted parents Other: _____

With whom did you live as you grew up? _____

Were your parents married? Y / N If yes, are they still married? Y / N

Describe your relationship with your parents: _____

Give a brief description of your father's personality, occupation, and state of health: _____

Give a brief description of your father's attitude toward you: _____

Complete this sentence: What I needed from my father and did not get was _____

Give a brief description of your mother's personality, occupation, and state of health: _____

Give a brief description of your mother's attitude toward you: _____

Complete this sentence: What I needed from my mother and did not get was _____

Using circles, indicate all of the ways you were disciplined as a child:

Threatened

Whipped/spanked

Beatings

Denied privileges

Lectured

Other (please explain): _____

Were you able to confide in your parents? Y / N

Did your parents understand you? Y / N

Did you feel loved by your father? Y / N

Did you feel loved by your mother? Y / N

Number of siblings in your family: _____ Brothers' ages _____ Sisters' ages _____

Describe past and present relationships with brothers: _____

Describe past and present relationships with sisters: _____

Circle the following activities your family participates or participated in (past or present). To the side, note the duration of time involved:

Alcohol consumption
Drugs
Compulsive gambling
Incest

Abuse (sexual or physical)
Witchcraft
Not known
Other, explain _____

Which of the circled above, if any, are currently being practiced?

If you circled any of the above, please use the following space if you wish to offer further explanation:

Explain how these activities may have affected you: _____

Personal Data

What type of counseling, if any have you received? _____

Again, what is your occupation? _____

Are you satisfied with your job? Y / N How many jobs have you had in the past 5 years? _____

At what age did you first learn about sex: _____

Who taught you about sexuality (circle all that apply):

Parents
Books/Magazines
Boyfriends/Girlfriends

School
Friends
Other (explain): _____

Complete this sentence: The one thing I cannot forgive is _____

Complete this sentence: What I need and never received from a man or woman is _____

Complete this sentence: One of the ways I can help myself but don't is _____

What is it about your present behavior that you would like to change? _____

Personal History

Complete the following sentences:

- I am a person who _____
- All my life _____
- Ever since I was a child _____
- One of the things I feel proud of is _____
- It's hard for me to admit _____
- Sometimes I feel guilty because _____
- One of the ways people hurt me is _____
- Sometimes I get angry because _____

What are some words that the following people might use to describe you (ex: happy, critical, hyper):

- Your spouse (if married): _____

- Your best friend: _____

- Someone who likes you: _____

- Someone who just met you: _____

- God: _____

- Yourself: _____

Please add any information that may help your therapist in understanding and helping you:
