

LIFE HISTORY QUESTIONNAIRE

Name of Client: _____ Date: _____

The information you provide will help in the planning of your counseling, and assist you and your therapist in clarifying your therapy goals. Please be as open and honest as possible. This questionnaire will be kept in your private confidential file.

Directions:

Please check all the items below that you currently experience or have difficulty with, and feel free to add any others at the bottom under "Other Concerns or Issues." You may add details as needed to clarify at the end of this questionnaire.

- | | | |
|---|---|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Grieving, Mourning | <input type="checkbox"/> Physical Problems |
| <input checked="" type="checkbox"/> Abuse - emotional | <input type="checkbox"/> Guilt | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Abuse - neglect | <input type="checkbox"/> Headaches, Pains | <input type="checkbox"/> Poor Self-care |
| <input type="checkbox"/> Abuse - sexual | <input type="checkbox"/> Health, Illness | <input type="checkbox"/> Pornography Use |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hostility | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Ambition | <input type="checkbox"/> Impulsive Spending | <input type="checkbox"/> Re-marriage |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Incest | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Indecision | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Self Abuse - burning |
| <input type="checkbox"/> Career Concerns | <input type="checkbox"/> Infertility | <input type="checkbox"/> Self Abuse - cutting |
| <input type="checkbox"/> Childhood Issues | <input type="checkbox"/> Inhibitions | <input type="checkbox"/> Self Abuse - other |
| <input type="checkbox"/> Children – care of | <input type="checkbox"/> Interpersonal Conflicts | <input type="checkbox"/> Self Abuse - scratching |
| <input type="checkbox"/> Children - custody | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Self Abuse – pulling hair out |
| <input type="checkbox"/> Children - management | <input type="checkbox"/> Irritability | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Choices I've Made | <input type="checkbox"/> Judgment Problems | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Laziness | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Legal Matters, Charges, Suits | <input type="checkbox"/> Self-neglect, Poor Self-care |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Compulsive Spending | <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Sexual Addiction |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Losses | <input type="checkbox"/> Sexual Conflicts |
| <input type="checkbox"/> Constant Conflicts | <input type="checkbox"/> Loss of Interest In Activities | <input type="checkbox"/> Sexual Desire Differences |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Loss of Interest In Sex | <input type="checkbox"/> Shyness |

- | | | |
|--|---|---|
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Debt | <input type="checkbox"/> Low Frustration Tolerance | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Decision Making | <input type="checkbox"/> Low Income | <input type="checkbox"/> Step-parenting |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Low Mood | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Marital Conflict | <input type="checkbox"/> Stress-management |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Marital Distance | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Marital Infidelity/Affairs | <input type="checkbox"/> Temper Problems |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Medical Concerns | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Drug Abuse – over the counter | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Thought Disorganization |
| <input type="checkbox"/> Drug Abuse - prescription | <input type="checkbox"/> Menopause | <input type="checkbox"/> Threats of Violence |
| <input type="checkbox"/> Drug Abuse – street drugs | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Drug Abuse - alcohol | <input type="checkbox"/> Mixed feelings | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Education | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Unhappiness |
| <input type="checkbox"/> Employment – lack of | <input type="checkbox"/> Motivation | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Employment - overdoing | <input type="checkbox"/> Mourning | <input type="checkbox"/> Violence – victim of crime |
| <input type="checkbox"/> Employment Problems | <input type="checkbox"/> Nail-biting | <input type="checkbox"/> Weight and Diet issues |
| <input type="checkbox"/> Employment - termination | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Withdrawal - isolating |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Work Problems |
| <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Obsessions, Compulsions | <input type="checkbox"/> Worry All The Time |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Outbursts | <input type="checkbox"/> Other concerns or issues: |
| <input type="checkbox"/> Fatigue, Low Energy | <input type="checkbox"/> Oversensitive to Criticism | |
| <input type="checkbox"/> Fears, Phobia | <input type="checkbox"/> Oversensitive to Rejection | |
| <input type="checkbox"/> Feelings of Helplessness/Hopeless | <input type="checkbox"/> Overweight | |
| <input type="checkbox"/> Financial Troubles | <input type="checkbox"/> Panic or Anxiety Attacks | |
| <input type="checkbox"/> Friendship Problems | <input type="checkbox"/> Parenting | |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Perfectionism | |
| <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Pessimism | |
| <input type="checkbox"/> Goals Not Being Met | <input type="checkbox"/> Phobias | |

Where did you attend high school? _____

Did you attend college/professional school? When, where, degree earned? _____

Any plans to further your education? Yes No If so, when and what? _____

What is your ethnic background?

- African/African American Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
 East Indian/Pakistani Latino/ Hispanic/ Mexican-American/ Puerto Rican
 Middle Eastern Native American/ Alaskan Native Polynesian/Micronesian
 White/Caucasian Other (specify) _____

How much do you identify with your ethnic heritage? (Check one):

- Not at all A little Somewhat Moderately Strongly

Religious/Spiritual preference: _____

Do you consider yourself a religious person? Yes No or spiritual person? Yes No

Comment: _____

Faith: Group/Denomination in which you were raised: _____

Current Congregation: _____

How active are you? Inactive Slightly Moderate Very

Does your family speak a language other than English at home? (Check one):

- Not at all Very little Sometimes Frequently Always

If "Sometimes" to "Always", what language is spoken? _____

Were you and both your biological parents born in the United States? Yes No Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40;etc.) _____

Have you seen another therapist before? Yes No

If yes, who did you see? _____

Have you ever been hospitalized for psychological/emotional difficulties? Yes No

If yes, please note dates of hospitalization _____

Are you or have you been on any medication for your psychological problems? Yes No

If yes, please note the type of medication, the dosage, and the dates you used this medication

Briefly describe the problem that brought you here.

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 2 3 4 5 6
Not intense Moderately intense Extremely intense

Problem Duration: Approximately how long have you had the current problem (in months or years)?

Coping Strategies: In what ways have you attempted to cope with this problem? _____

Expectations: What do you hope to accomplish by coming to therapy? Be as specific as possible.

Have you been married/partnered before? Yes No If yes, when and for how long? _____

Please list the names of your children or dependents.

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

List others who may live with you including their ages and occupations (e.g. brother 16, student, mother-in-law 55, etc.)

Please check any past, present, or impending special problems in your family:

- | | | |
|--|---|---|
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Divorce | <input type="checkbox"/> Frequent relocations |
| <input type="checkbox"/> Serious illness | <input type="checkbox"/> Debilitating injuries/disabilities | <input type="checkbox"/> Alcohol/drug abuse |
| <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Physical/sexual abuse | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Financial crisis/unemployment | <input type="checkbox"/> Attempted/completed suicide | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Other _____ | | |

Please specify family member(s), with special problems, and approximate year of occurrence (e.g. mother, serious illness, 1998.)

Would you like anyone else involved in the counseling with you? (family members, friends, etc.)

Is there a concern about violence in your life today (either from you or towards you)? Please explain:

Have you personally experienced significant family abuse?

- None Unsure Emotional Physical Sexual

Have you personally experienced legal problems? Yes No

Did you experience learning problems in elementary or high school? (Check one):

- None A little Some Substantial Lots, constant struggle

In general, how happy or adjusted were you growing up? (Check one):

- Not at all A little About average Substantial Completely

How much is your family a source of emotional support for you now? (Check one):

- None A little Somewhat Substantial Very strong

How much conflict in values do you currently experience with your parents? (Check one):

- Very little or none Some Moderate Strong Extreme

Who in your family do you currently feel closest to?

Most distant from? _____ In most conflict with? _____

If you are married or in a committed relationship, are you currently in the process of separation or divorce?

Please specify:

What is the length of time apart?

How committed are you to making your marriage/relationship work? _____

What changes are you willing to make for the sake of your marriage/relationship? _____

Describe any concerns regarding sexual or emotional intimacy with your spouse/partner. _____

Please list any other information that you believe will be helpful for your therapist to know.

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, diabetes, headaches, etc.)

Are you presently taking any prescribed or non-prescribed medication? Yes No

Please indicate _____

Are you having any problems with your sleep habits? Yes No

If yes, check where applicable: Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other _____

How many times per week do you exercise? _____ About how long each time? _____

Are you having any difficulty with appetite or eating habits? Yes No

If yes, check where applicable: Eating less Eating more Binging Poor appetite

Making myself vomit Significant weight change (last two months)

Do you regularly use alcohol? Yes No

In a typical month, how often do you have four or more drinks in a 24 hour period? _____

Do you consider your alcohol consumption a problem? Yes No Unsure

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
Do you consider this drug use a problem? Yes No Unsure

Do you have any problems or worries about sexual functioning? Yes No
If yes, check where applicable: Lack of desire Performance problem Difficulty maintaining arousal
 Worried about sexually transmitted disease Sexual impulsiveness
 Other _____

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?
 Frequently A few times Once Never Unsure

Have you had suicidal thoughts in the last few months ?
 Frequently Sometimes Rarely Never

Have you had them in the past?
 Frequently Sometimes Rarely Never

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

In the past, how would you rate the quality of your peer relationships?
 Very poor Unsatisfactory About average Good Excellent

Approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? Yes No I think so

Besides family members, approximately how many people can you really count on right now for friendship or emotional support? _____

List them below:

Please enter any additional information about your life history here:
