Date: ______________________

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain some information about you so that I can better meet your request for service. Completing this questionnaire as fully and as accurately as you can will facilitate the development of your therapy experience.

It is understandable that you may be concerned about what happens to this information about you, because this information is highly personal. As explained in the information form that you read, all material in your file is strictly confidential.
If you prefer not to answer any question, just write: N/A (No answer). If you need extra space, use reverse side.

1. General Information (please print)

Name: ____

Address: ____
postal code: ___________________

Telephone: (home)__________(office) __________(cel) __________
Permission to leave message? home: Yes / No office: Yes / No cell: Yes / No

Age: __________Date of Birth: __________

Education: ____
Occupation and employment situation: ____
____

Relationship Status: (circle one; the following items)

Single, Married, Common-Law, Separated, Divorced, Remarried, Widowed

If you have a partner:
How long have you been together? __________
How long have you been living together? _________
Age of partner: _______
Education and occupation of partner: ____

Do you have children? ☐Yes ☐No
If yes, how many live with you?___________________________
Please list your children's names, age and gender: _______________________
____

2. Medical History

Name of family physician:_________________________________
Telephone number:_________________________________
May I have permission to contact your medical doctor and acknowledge that you are attending therapy?
☐Yes ☐No

Have you ever had . . . ? (Circle any problems applicable)

Headache	High blood pressure	Gastritis or esophagitis	Other hormonal problem
Head injury	Angina or chest pain	Irritable bowel	Chronic pain
Loss of consciousness	Heart attack	Other intestinal problems	Bone or joint problems
Seizures	Heart rhythm disturbances	Kidney problems	Chronic fatigue
Dizziness or faintness	Heart valve problems	Other urinary tract problems	Fibromyalgia
Numbness and tingling	Shortness of breath	Diabetes	Hepatitis
Weakness	Asthma	Thyroid problems	AIDS
Coordination problems	Tuberculosis	Menstrual problems	Allergies

Other:

Current Symptoms and Problems (Circle any problems you have experienced in the past month)

Depression	Unhappy with your situation	Short attention span	Hallucinations
Grief/Loss	Pessimism about the future	Memory problems	Paranoid thoughts
Anxiety	Traumatic memories	Compulsive behaviors	Other unusual thoughts
Panic attacks	Nightmares	Compulsive overeating	Self-destructive behavior
Fears/phobias	Sleep disturbance	Anorexia	Suicidal urges
Obsessional worry	Appetite changes	Bulimia	Aggressive urges
Feeling helpless or trapped	Fatigue/energy problems	Alcohol abuse or dependence	Other:
Unhappy with yourself	Inability concentrating	Drug abuse or dependence	

Do you currently have any medical problems that require treatment? ☐Yes ☐No

If YES, please describe the problem and nature of the treatment:

Are you taking any medication at this time? ☐Yes ☐No

If YES, please list (include both prescription & non-prescription medication):

What other serious medical problems or accidents have you had?

Do you have any special physical needs? (please describe)

3. **Chemical Use:**

Do you use recreational drugs? ☐Yes ☐No

If YES, please list: ____________________

How frequently do you use alcohol? ____________________

How much beer, wine or hard liquor do you consume each week?____________________

Have you ever been criticized for your drinking or drug use?____________________

Have you ever felt guilty for your alcohol or drug use?____________________

How do drugs and/or alcohol effect you?____________________

4. **Comfort:** Do you/did you ever turn to alcohol, drugs, sex, pornography, gambling, food, shopping or other material things ______________(describe) for comfort? (Circle relevant items.)

5. **Social Network**

Do you have someone with whom you can share personal problems or go to for comfort? ☐Yes ☐No

If yes, who is it? ____________________

How do you spend your leisure time?

____

Do you belong to any clubs or organizations (eg. church group, bowling team, PTA etc…)?

6. **Family History**

Relative: Name	Current age (or age at death)	Illness (or cause of death)	Education	Occupation
Father:				
Mother:				
Others(step parents/grandparents):				
Siblings:				

(Use reverse side if necessary)

If you were to choose three adjective to describe your mother, as you were growing up, what would they be?______________, _______________, __________.
What sort of relationship did you have with your mother? ______________________

If you were to choose three adjective to describe your father, as you were growing up, what would they be?______________, _______________, __________.
What sort of relationship did you have with your father? ______________________

Were your parents openly affectionate? _______________ Did they fight? _____________________

Did they resolve arguments and get close again? _________________

Who did you go to for comfort as a child?_________________________

Comment on any significant relationships that have been influential in your experience growing up. (Use reverse side if necessary):

7. **Relationship History:**

Partner's name	Partner's age when relationship began	Your age when relationship began	Your age when relationship ended
1.:			
2.:			
3.:			

Were you able to find comfort from your previous relationships? ______________________

Current Relationship:

Level of commitment to relationship:
1 2 3 4 5
Low High
(Circle number)

Level of distress in relationship:
1 2 3 4 5
Low High

8. **Cultural/Religious Information:**

1. What is your race/ethnicity? _____________________________________

2. How much do you identify with your ethnic heritage?

1 2 3 4 5
Not at all Strongly

3. Religious or spiritual preference _____________________________________

4. Are you currently active in your religion/spiritual practice?

1 2 3 4 5
Not at all Somewhat Yes

Are there any specific aspects about your ethnic or religious values and/or experience that you feel would be helpful for me to know? If so, please describe:

____

____

____

9. **Other Information**

Do you have difficulty sleeping? ☐ Yes ☐ No

Have you experienced abuse? None: ☐ Not Sure: ☐ Yes: ☐

Physical abuse   Emotional abuse   Sexual abuse
(Please circle what you have experienced)

Is there any other information you think may help the therapist understand you?

10. **Expectations for Therapy**

What prompted you to seek therapy at this time?

What changes would you like to make?

11. **Referral: How did you find out about me?** ______________________

If someone suggested that you call this office, please provide name and contact information (optional):

Name: ______________________ Phone: ______________________

Address: ____

May I have permission to contact this person and acknowledge the referral? ☐ Yes ☐ No

Thank you for taking time to complete this form.