



Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic program. This questionnaire will save you both time and expense. You are requested to answer these routine questions in your own time, instead of using up your actual counseling time.

It is understandable that you might be concerned about what happens to the information about you, because much or all of this information is highly personal. Case records are strictly confidential. No outsider, not even your closest relative or family doctor is permitted to see your case record without your written permission.

IMPORTANT: If you do not desire to answer any question, write "Do not care to answer." Also, if some particular question does not apply to you, simply write "NA" in the space provided.

Your Counselor's Name: _____ Appointment Date: _____

1. GENERAL INFORMATION

Patient's Name _____

Spouse's Name _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Occupation _____

Home Telephone _____ Work Telephone _____

Email_____Cellular phone_____

Please Circle One:

Minor Married Single Engaged Divorced Widowed Separated

Referred by:_____

Religious Denomination_____

Attendance (circle):

Regular Occasional Never

With whom are you now living?

(List people, their names, ages & occupations. If they are students, indicate what grade:

List 3 people not mentioned above who are important to you; people who are your closest friends.
First names only will be fine.

How strongly do you want counseling for your problems? (circle one)

Very much Much Moderately Could do without, if necessary

2. CLINICAL INFORMATION

You can help us save time by explaining in your own words some things about your problem.
Please be as specific as possible. A few particular examples of how the problem comes up would be valuable.

State in your own words the nature of your chief concern:_____

If your problem is something that you think happens too often, state approximately how often it occurs, how long it lasts, and any other information you feel might be helpful in understanding your problem.

2. If your problem concerns something not happening as often as you would like, state what you would like to see happen more often, how often you think it should occur, etc.

If you have had previous counseling for this problem, state with whom and describe the outcome.

With whom else have you discussed this problem?

3. DEVELOPMENTAL INFORMATION

Date and place of birth: _____

Approximately how many times did your family move when you were young? _____

Since you left your parental home? _____ Your age when you left? _____

Childhood:

1. Mother's condition during pregnancy (as far as you know):

2. Underline any of the following that apply during your childhood:

night terrors; bed wetting; sleep-walking; thumb-sucking; nail-biting; stammering; fears; happy childhood;
unhappy childhood; no memories of childhood.

Health:

1. Health during childhood: _____

2. List childhood illnesses: _____

3. Health during adolescence: _____

4. List adolescent disabilities: _____

5. List physical disabilities: _____

How do any of these health issues relate to your present problem?

6. Your present height: _____ Weight: _____

7. List any surgical operations and at what age they occurred:

8. List all prescription and non-prescription drugs you now take (include dosage):

9. When was the last time you felt well, both physically and emotionally, for a fair amount of time?

10. Underline any of the following that apply to you:

headaches; dizziness; fainting spells; palpitations; stomach trouble; no appetite; bowel disturbances; fatigue;

insomnia; nightmares; take sedatives; alcoholism; feel tense; feel panic; tremors; depressed; suicidal ideas; drugs;

unable to relax; sexual problems; unable to have a good time; don't like weekends and vacations; over-ambitious;

shyness; can't make friends; feel lonely; can't make decisions; can't keep a job; inferiority feelings; home

conditions bad; financial problems; hear voices; relationships difficult or impaired; difficulty with intimacy either

sexual or emotional.

Other: _____

11. List your childhood friends.

a. Elementary school: _____

b. Junior High school: _____

c. Senior High school: _____

12. When did you begin dating? _____

a. List the most important girl or boyfriend that you had in your childhood:

b. Did you become sexually active in your teen years? _____

Complete the following sentences:

1. As a child, I... _____

2. For me, school was... _____

3. My childhood fears were... _____

4. My childhood ambitions were..._____

5. My role in my group of friends was..._____

6. The significant events in my physical and sexual development were..._____

7. The significant events in my social development were..._____

8. The most important values in my family were..._____

9. What stands out the most for me about my family life is..._____

10. My parents' relationships to each other was..._____

11. My brothers' and sisters' relationships to Dad were..._____

12. My brothers' and sisters' relationships to Mother were..._____

13. What I loved to do as a child younger than 10 years old was to _____

AVOCATIONAL INTERESTS

Games and interests during childhood (including make-believe):_____

Interests and hobbies during adolescence:_____

Athletic interests and/or accomplishments: _____

Present interests, hobbies, activities, organizations: _____

Present use of free time: _____

EDUCATION

Last grade or year completed: _____

Degree(s): _____

Date(s): _____

Relationship to schoolmates: _____

Scholastic abilities & disabilities: _____

Were you ever bullied, or given a nickname? Please explain briefly: _____

Do you make friends easily? Do you keep them? _____

Did you ever experience any anxieties or guilt feelings or trauma arising out of sexual experience with the same sex (homosexuality)? If yes, please explain.

Have you ever experienced any sexual abuse or trauma?

Do you know from whom you experienced the abuse?

What was the nature of the abuse?

List any other details which you would consider relevant. _____

Menstrual History: Age at first period _____

Were you informed, or did it come as a shock?

Are you regular? _____ Duration _____

Do you have pain? _____ Do your periods affect your moods? How? _____

Is there any question or concern you have about sex; past, present, or future? Is there any question about your sexual orientation?

MARITAL HISTORY – Present Marriage:

How long did you know your marriage partner before engagement? _____

How long were you engaged? _____ How long have you been married? _____

Please describe below something of what you liked and disliked about your mate:

1. What I liked the first few years: _____

2. What my mate liked the first few years: _____

3. What I disliked the first few years: _____

4. What my mate disliked the first few years: _____

5. What I have liked the last few months: _____

6. What I have disliked the last few months: _____

7. What my mate has liked/disliked the last few months: _____

In what areas are you and your mate most compatible? _____

In the following section, "Father" refers to the man who took primary responsibility for raising you. If that is a different person from your biological father, please describe what you know of your biological father on the back of this page, and describe your "father" on this page.

Father's Name _____

Current Age _____

Occupation _____

Health: (circle) Good Average Poor

If deceased, cause of death and age at death _____

Your age at the time _____

1. Kind of person: _____

2. His ambitions for the children: _____

3. His relationship to the children: _____

4. His relationship to Mother (his wife): _____

5. His favorite child (explain): _____

6. Which child was most like Dad? How? _____

7. Which child was most different from Dad? How? _____

8. As a child, what I liked about Dad: _____

9. As a child, what I disliked about Dad: _____

In the following section, "Mother" refers to the woman who took primary responsibility for raising you. If that is a different person from your biological mother, please describe what you know of your biological mother on the back of this page, and describe your "mother" here.

Mother's Name _____

Current Age _____

Occupation _____

Health: (circle) Good Average Poor

If deceased, cause of death and age at death _____

Your age at this time _____

1. Kind of person: _____

2. Her ambitions for the children: _____

3. Her relationship to Father (her husband): _____

4. Her relationship to the children: _____

5. Her favorite child (explain): _____

6. Which child was most like Mom? How? _____

7. Which child was most different from Mom? How? _____

8. As a child, what I liked about Mom: _____

9. As a child, what I disliked about Mom: _____

10. SELF-DESCRIPTION

In what kinds of situations do you most readily lose self-control? (Cite particular instances if at all possible. Examples might be temper, uncontrollable crying, impatience, etc.)

In which situations are you best able to maintain self-control?

How do you believe you would be described by?:

1. Your spouse: _____

2. Your best friend: _____

3. Your worst enemy (even if you don't really have one): _____

4. Yourself: _____
