LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is for you and your counselor to get a good look at your life. This will help shape the goals and methods of your work together. Most people learn new things about themselves that they had not known before. All material here will be kept strictly confidential. If you do not want to answer an item, simply leave it blank.

Brief Background Information

Name: _____ Date of birth: _____

Phone number: _____ Email: _____

Marital status: ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed
Do you have children? ☐ Yes ☐ No
If so, how many and what ages? _____

Do you have any siblings? ☐ Yes ☐ No

If so, how many and what ages? _____

Information About My Lifestyle

1. What do you do to relax?

2. What aspects of your life are stressful?

3. Length of work day (hours)? _____. Length of work week (days)? _____

4. How do you deal with stress?

5. Alcohol consumption: Daily: _____ Weekly : _____

6. Recreational drug use: ☐ Yes ☐ No
   If so, what kind and how often?

7. Name and amounts of prescribed medications that I am taking:

8. Name and amounts of non-prescribed medications/drugs that I am taking:

9. Coffee or other caffeinated drink, daily consumption:

10. Cigarette/cigar consumption daily:

11. The following people in my family have a history of substance abuse of some kind:

12. The social/supportive activities and groups I am involved in are:

13. What best describes the overall environment of your childhood home?
    - ☐ Unconditional love and acceptance; close relationships
    - ☐ Quiet and peaceful, but relationships were distant
    - ☐ Instability, periods of family peace mixed with periods of fighting and/or crisis.

About My Father (S)

My father:

Relationship with father :	☐ Close	☐ Good	☐ Fair	☐ Indifferent	☐ None
We communicated together:	☐ Well	☐ Okay	☐ Fair	☐ Poorly	☐ Not At All
Were you ever abused by your father?		☐ Verbally	☐ Physically	☐ Sexually	☐ Neglect

If yes give some details about this part of your life:

My stepfather (or other significant fathering person in your life):

Relationship with stepfather:	☐ Close	☐ Good	☐ Fair	☐ Indifferent	☐ None
We communicated together:	☐ Well	☐ Okay	☐ Fair	☐ Poorly	☐ Not At All
Were you ever abused by your stepfather?		☐ Verbally	☐ Physically	☐ Sexually	☐ Neglect

If yes give some details about this part of your life:

About My Mother (S)

My mother:

Relationship with mother:	☐ Close	☐ Good	☐ Fair	☐ Indifferent	☐ None
We communicated together:	☐ Well	☐ Okay	☐ Fair	☐ Poorly	☐ Not At All
Were you ever abused by your mother?		☐ Verbally	☐ Physically	☐ Sexually	☐ Neglect

If yes give some details about this part of your life:

My stepmother (or other significant mothering person in your life):

Relationship with stepmother:	☐ Close	☐ Good	☐ Fair	☐ Indifferent	☐ None
We communicated together:	☐ Well	☐ Okay	☐ Fair	☐ Poorly	☐ Not At All
Were you ever abused by your stepmother?		☐ Verbally	☐ Physically	☐ Sexually	☐ Neglect

If yes give some details about this part of your life:

Information About My Emotions

1. What is your temperament? (I.e. tend to be patient/impatient, calm/easily agitated, even tempered/moody, angry)

2. Which event (or period of time) has been the most traumatic to you in life? Use the back side of this paper as necessary)

The current symptoms that I experience are as follows (check all items that apply to you right now or in the recent past):

- ❑ Anxious
- ❑ Can't keep friends
- ❑ Indecisive
- ❑ Impulsive
- ❑ Distant from others
- ❑ Suicidal thoughts/feelings
- ❑ I feel discouraged about the future
- ❑ My mind races a lot
- ❑ I have periods of time I can't remember
- ❑ Relationship problems at work
- ❑ Painful childhood memories
- ❑ I have periods where I don't eat for day(s)
- ❑ Shortness of breath
- ❑ I often feel like a failure
- ❑ I rarely feel sad
- ❑ I am disappointed in my self
- ❑ I am easily agitated
- ❑ Difficulty talking about my feelings
- ❑ I get tired more easily than I used to
- ❑ My appetite is not as good as it used to be
- ❑ Depressed
- ❑ I feel lonely often
- ❑ Financial problems
- ❑ Tension problems
- ❑ Tension headaches
- ❑ Rage outbursts
- ❑ Moody
- ❑ Clench jaw
- ❑ Concentration problems
- ❑ Conflict home life
- ❑ Wary and distrustful of others
- ❑ I am very critical of my self
- ❑ I have difficulty sleeping
- ❑ I often worry about other problems
- ❑ Hopeless feelings
- ❑ I worry about dying a lot
- ❑ Nervous stomach
- ❑ I have nightmares
- ❑ I often doubt myself
- ❑ Sometimes I feel like I can't stop crying
- ❑ I often do things I really don't want to do
- ❑ I feel like I don't have enough time to relax
- ❑ I some times eat a lot and then I throw up
- ❑ I often have a hard time saying "no"
- ❑ When I get angry, I stay angry for hours
- ❑ I am less interested in other people & activities now than I used to be

Information About My Spiritual Beliefs/Practices

On a scale from 1 to 5 where 1 indicates strongly agree and 5 indicates strongly disagree please rate the following

Strongly agree	Agree	Neutral	disagree	strongly disagree
1	2	3	4	5

I believe in a Higher Power or God ..... ☐
Spirituality is important to me ..... ☐
I know my purpose in life ..... ☐
I follow a spiritual practice ..... ☐
I feel connected to myself, others and my community ..... ☐
I would like to practice more inner work ..... ☐

Presenting Issue(s)
I have previously received counseling: ☐ Yes ☐ No

During the following periods of time:

I have participated in the following forms of therapy/counseling/practices:

- ❑ Group
- ❑ Meditation
- ❑ Psychotherapy
- ❑ Journaling
- ❑ Self growth training/workshops
- ❑ Hypnotherapy
- ❑ Mental Imagery
- ❑ Stress Management
- ❑ Biofeedback
- ❑ Music
- ❑ Art
- ❑ Therapeutic touch
- ❑ Vision quest
- ❑ Dream-Work
- ❑ Breath-Work
- ❑ Other

Please name
_____
_____
_____

What did you like about counseling?

What didn't you like about counseling?

I have been hospitalized for mental/emotional problems at the following times and places:

Diagnosis with a mental illness:

If so, when were you diagnosed:

What are the primary concerns that bring you here for treatment?

Physical:

Mental:

Emotional:

Spiritual:

How do these issues interfere with your daily functioning?

When and how did these problems begin?

What specific behavior change goals do you have for yourself in counseling and treatment?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE!