

##### LIFE HISTORY QUESTIONNAIRE

###### Page 1

Thank you for completing this questionnaire. Your answers will support you and your counselor to get a good look at your life and shape the goals of your work together. All material here will be kept strictly confidential. If you do not want to answer an item, simply leave it blank.

##### Contact & Personal Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronouns: She/Her, He/Him, They/Them, Ze

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I email you? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

*Please note email correspondence is not considered to be a confidential form of communication.*

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Marital status: 🖵 Married 🖵 Partner 🖵 Single 🖵 Divorced 🖵 Separated 🖵 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose for Seeking Counseling**

1. What is the primary reason you are seeking counseling at this time?

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1. What are the three most important intentions or goals you would like to experience?

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1. What tends to inhibit you from moving forward in these areas?

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1. Have you lost any parts of yourself you would really like to have back in your life?

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###### Page 2

Which event (or period of time) has been the most stressful or traumatic to you in life?

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

🖵 Unhealthy and abusive either mentally, emotionally, physically, sexually or neglect

Who loved you unconditionally from 0 to 18 years of age? Who gave you positive reinforcement?

Please rate the following symptoms that you are currently experiencing or have experienced in the past 12 months using the following scale. **0 Never 1 Rarely 2 Occasionally 3 Frequently 4 Very Frequently**

\_\_\_\_ 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 feel like a failure

\_\_\_\_I feel sad

\_\_\_\_I am disappointed in my self

\_\_\_\_I am easily agitated

\_\_\_\_Difficulty talking about my feelings

\_\_\_\_I get tired easily

\_\_\_\_I tend to overeat

\_\_\_\_Depressed

\_\_\_\_I lonely often

\_\_\_\_Financial problems

\_\_\_\_Tension problems

\_\_\_\_ Headaches

\_\_\_\_Rage outbursts

\_\_\_\_Moody

\_\_\_\_Clench jaw

\_\_\_\_Concentration problems

\_\_\_\_Conflictual home life

\_\_\_\_Wary and distrustful of others

\_\_\_\_I am very critical of my self

\_\_\_\_I have difficulty sleeping

\_\_\_\_I worry about other problems

\_\_\_\_Hopeless feelings

\_\_\_\_I worry about dying

\_\_\_\_Nervous stomach

\_\_\_\_I have nightmares

\_\_\_\_I doubt myself

\_\_\_\_Sometimes I feel like I can’t stop crying

\_\_\_\_I do things I really don’t want to do

\_\_\_\_I feel like I don’t have enough time to relax

\_\_\_\_I have a hard time saying “no”

\_\_\_\_When I get angry, I stay angry for hours

\_\_\_\_I have little interest in other people & activities

Have you had any serious accidents/head injuries? If so, please explain.

Do you have any serious or chronic medical conditions? If so, please explain.

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###### Page 3

**Counseling and Personal Development**

Have previously received counseling: 🖵 Yes 🖵 No

If so, when or during what periods of time in your life:

Name and amounts of prescribed medications that you are taking:

Name and amounts of non-prescribed medications/drugs that you are taking, including CBD/THC:

Check any of the following forms of therapy and practices you have participated in.

* Brainspotting
* EMDR
* Somatic Therapy
* EFT
* Group
* Meditation
* Psychotherapy
* Journaling
* Self growth training/workshops
* Hypnotherapy
* Mental Imagery
* Stress Management
* Biofeedback
* Music
* Art
* Vision quest
* Dream-Work
* Breath-Work
* Other

Please name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you like about counseling?

What didn’t you like about counseling?

##### Information About Your Lifestyle

1. Length of work day (hours) \_\_\_\_\_\_\_\_\_\_. Length of work week (days) \_\_\_\_\_\_\_\_\_\_
2. Coffee or other caffeinated drink, daily consumption \_\_\_\_\_\_\_\_\_
3. How many times per week do you exercise \_\_\_\_\_\_\_\_\_
4. How would you rate your current level of balance between work and life?

\_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Imbalanced

1. What do you do to relieve stress or relax?

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1. Alcohol consumption: Daily: \_\_\_\_\_\_\_\_\_ Weekly: \_\_\_\_\_\_\_\_
2. Recreational drug use: 🖵 Yes 🖵 No

If so, what kind and how often?

1. The following people in your family have a history of substance abuse of some kind:
2. The social/supportive activities and groups you are involved in:
3. Who loves you and supports you in your life now?

##### Information about Your Spirituality

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 🖵

What is the most important thing I should know about you?

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What are some of your strengths?

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What else would you like for me to know about you to support our work together?

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**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE!**