LIFE HISTORY QUESTIONNAIRE

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?

_____

_____

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

_____

_____

_____

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

_____

_____

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

_____

_____

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.

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

6. Alcohol consumption: Daily: _____ Weekly: _____

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

8. The following people in your family have a history of substance abuse of some kind:

9. The social/supportive activities and groups you are involved in:

10. 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?

_____

_____

What are some of your strengths?

_____

_____

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

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE!