Provider: _____

Life History Questionnaire *(All files are held in strict confidence)*

Date _____ _____ SSN: ____-____-_____ Health Insurance Provider_____

First Name _____ MI ____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender: ☐ Male ☐ Female

Home Address	City	State	ZIP

Home Phone ☐ May We Leave A Message?	Cell Phone ☐ May We Leave A Message?

Email Address ☐ May We Send A Message?	Education Level:

Employer Name	Work Phone ☐ May We Leave A Message?

Work Address	City	State	Zip

Ethnicity ☐ Asian/Pacific Islander ☐ Caucasian ☐ Native American ☐ Latino ☐ Other: _____ ☐ African American

Relationship Status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please indicate who referred you to the Counseling Center

Referral Type ☐ Friend ☐ Other Therapist ☐ Other ☐ Advertisement ☐ Healthcare Provider

Referral Name / Source

Please read the following questions and mark those to which you would respond "yes."

☐ Have you previously been involved in counseling?
Therapist Name: _____
Reason: _____
Dates: _____
Outcome: _____

☐ Have you ever been hospitalized for mental health reasons?
Hospital Name: _____
Reason: _____
Dates: _____
Outcome: _____

☐ Do you currently use alcohol or other non-prescription drugs?
What: _____
Amount: _____
How long have you used: _____

☐ Are you currently taking any prescription medications?
What: _____
Amount/How Long: _____
Prescribing MD: _____

☐ Is there a history of mental health problems in your family?
☐ Have you ever been physically abused?
☐ Have you ever been emotionally abused?
☐ Are your concerns interfering with your daily life?
☐ Have you ever been in legal trouble?
☐ Have you ever been sexually abused or assaulted?
☐ Is there a history of alcohol or drug problems in your family?
☐ Have you ever attempted suicide?

Briefly explain your need for counseling now:

How long has this problem persisted?

Under what condition do your problems get worse? better?

Please use the following scale to answer the next three questions:

	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History:

Mother's Age _____ If deceased, how old were you when she died? _____

Father's Age _____ If deceased, how old were you when he died? _____

If your parents are separated, how old were you when they separated? _____

Number of brother(s) _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Number of sister (s) _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name of Spouse/Significant Other: _____ Years Together: _____

Age _____ | Date Of Birth _____ | Gender: ☐ Male ☐ Female

Education Level | Occupation

Previous Marriages: _____ Name of Previous Spouse: _____ Years Married _____

Nature of Relationship (i.e. friendly, distant, physical/emotional abuse, loving, hostile)

Number of Children _____ What are their ages? _____ _____ _____ _____ _____ _____

Names: _____

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Nightmares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you:

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name of Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

_____ _____

Signature Date

For Staff Use

Dx Code 1: _____ Dx Code 2: _____

Therapist's Signature/Credentials: _____

Date: _____