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LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, you will facilitate your therapy. The information you provide is strictly confidential. If you do not desire to answer any questions, merely write "Do Not Care to Answer."

Date_____

1. GENERAL INFORMATION

Name:_____

Address:_____

_____

Telephone Numbers: Home_____ Business_____

Fax Number:_____ E-mail Address:_____

Age:_____ Occupation_____ Sex_____

Marital Status (circle one): Single Married Separated Divorced Widowed

Remarried (how many times?_____) Living with someone?_____

2. DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problem(s)

On the scale below please estimate the severity of your problem(s)

Mildly Upsetting____	Moderately Upsetting____	Very Severe____	Extremely Severe____	Totally Incapacitating____

When did your problem(s) begin? (Give dates):
Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of your problems.

What solutions to your problems have been most helpful up until now?

Have you been in therapy before or received any prior professional assistance for your problems? If so, please give name(s), professional title(s), dates of treatments and results.

3. PERSONAL AND SOCIAL HISTORY

(a) Date of Birth_____ Place of Birth_____

(b) Siblings: Number of Brothers_____ Brothers' Ages_____

Number of Sisters_____ Sisters' Ages_____

(c) Father: Living?_____ If alive, give father's present age_____

If deceased, give his age at time of death_____

If deceased, how old were you at the time?_____

Cause of Death_____

Occupation_____ Health_____

(d) Mother: Living?_____ If alive, give mother's present age_____

If deceased, give her age at time of death_____

If deceased, how old were you at the time?_____

Cause of Death_____

Occupation_____ Health_____

(e) Religion: As a Child_____ As an Adult_____

(f) Education: What is the last grade completed (degree)?_____

(g) Scholastic Strengths and Weaknesses:

(h) Underline any of the following that applied during your childhood/adolescence:

Happy Childhood	School Problems	Medical Problems
Unhappy Childhood	Family Problems	Alcohol Abuse
Emotional/Behavior Problems	Strong Religious Convictions	Others
Legal Trouble	Drug Abuse	

(i) What sort of work are you doing now?

(j) What kinds of jobs have you held in the past?

(k) Does your present work satisfy you? If not, please explain.

(l) What is your annual family income?_____

How much does it cost you to live?_____

(m) What were your past ambitions?

(n) What are your current ambitions?

(o) What is your height?_____ What is your weight?_____

(p) Have you ever been hospitalized for psychological problems?_____ If yes, when and where?

(q) Do you have a family physician? Yes____ No____ If yes, please give his/her name(s) and

telephone numbers(s)_____

(r) Have you ever attempted suicide?

(s) Does any member of your family suffer from alcoholism, epilepsy, depression or anything else that might be considered a mental disorder? If so, elaborate:

(t) Has any relative attempted or committed suicide? If so, elaborate:

(u) Has any relative had serious problems with the "law"? If so, elaborate:

ANALYSIS OF CURRENT PROBLEMS

The following section is designed to help you describe your current problems in greater detail and to identify problems which might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs.

4. BEHAVIOR

Underline any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job
Take drugs	Compulsions	Insomnia
Vomiting	Smoke	Take too many risks
Odd behavior	Withdrawal	Lazy
Drink too much	Nervous tics	Eating problems
Work too hard	Sleep disturbance	Aggressive behavior
Procrastination	Phobic avoidance	Crying
Impulsive reactions	Outbursts of temper	
Loss of control	Concentration difficulties	

Are there any specific behaviors, actions or habits that you would like to change?

What are some special talents or skills that you feel proud of?

What would you like to do more of?

What would you like to do less of?

What would you like to start doing?

What would like to stop doing?

How is your free time spent?

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities? If so, elaborate:

Do you practice relaxation or meditation regularly? If so, elaborate:

5. FEELINGS

Underline any of the following feelings that often apply to you:

Angry	Guilty	Unhappy
Annoyed	Happy	Bored
Sad	Conflicted	Restless
Depressed	Regretful	Lonely
Anxious	Hopeless	Contented
Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense
Envy	Jealous	Others:

List your five main fears:

1.

2.

3.

4.

5.

What feelings would you most like to experience more often?

What feelings would you like to experience less often?

What are some positive feelings you have experienced recently?

When are you most likely to lose control of your feelings?

Describe any situations that make you feel calm or relaxed.

Please complete the following:

If I told you what I'm feeling now

One of the things I feel proud of is

One of the things I feel guilty about is

I am happiest when

One of the things that saddens me the most is

If I weren't afraid to be myself, I might

I get so angry when

If I get angry with you

What kinds of hobbies or leisure activities do you enjoy or find relaxing?

Do you have trouble relaxing and enjoying weekends and vacations? If so, please elaborate:

6. PHYSICAL SENSATIONS

Underline any of the following that often apply to you:

Headaches	Stomach trouble	Skin problems
Dizziness	Tics	Dry mouth
Palpitations	Fatigue	Burning or itchy skin
Muscle spasms	Twitches	Chest pains
Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Don't like being touched
Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating
Tingling	Watery eyes	Visual disturbances
Numbness	Flushes	Hearing problems

Menstrual History:

Age of first period

Were you informed or did it come as a shock?

Are you regular?

Date of last period_____ Duration_____

Do you have pain? Do your periods affect your mood?

What sensations are especially

Pleasant for you?

Unpleasant for you?

7. IMAGES

Underline any of the following that apply to you:

Pleasant sexual images Unpleasant sexual images
Unpleasant childhood imagesLonely images
Helpless images Seduction images
Aggressive images Images of being loved

Check which of the following applies to you:

I picture myself:

being hurt hurting others
not coping being in charge
succeeding failing
losing control being trapped
being talked about being promiscuous
others:

What picture comes into your mind most often?

Describe a very pleasant image, mental picture, or fantasy.

Describe a very unpleasant image, mental picture, or fantasy.

Describe your image of a completely "safe place."

How often do you have nightmares?

8. THOUGHTS

Underline each of the following thoughts that apply to you:

I am worthless, a nobody, useless and/or unlovable.
I am unattractive, incompetent, stupid and/or undesirable.
I am evil, crazy, degenerate and/or deviant.
Life is empty, a waste; there is nothing to look forward to.
I make too many mistakes, can't do anything right.

Underline each of the following words that you might use to describe yourself:

intelligent, confident, worthwhile, ambitious, sensitive, loyal, trustworthy, full of regrets, worthless, a nobody, useless, evil, crazy, morally degenerate, considerate, a deviant, unattractive, unlovable, inadequate, confused, ugly, stupid, naive, honest, incompetent, horrible thoughts, conflicted, concentration difficulties, memory problems, attractive,
can't make decisions, suicidal ideas, persevering, good sense of humor, hard-working

What do you consider to be your most irrational thought or idea?

Are you bothered by thoughts that occur over and over again?

On each of the following items, circle the number that most accurately reflects your opinions:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I should not make mistakes	1	2	3	4	5
I should be good at everything I do	1	2	3	4	5
When I do not know, I should pretend that I do	1	2	3	4	5
I should not disclose personal information	1	2	3	4	5
I am a victim of circumstances	1	2	3	4	5
My life is controlled by outside forces	1	2	3	4	5
Other people are happier than I am	1	2	3	4	5

It is very important to please other people	1	2	3	4	5
Play it safe; don't take any risks	1	2	3	4	5
I don't deserve to be happy	1	2	3	4	5
If I ignore my problems, they will disappear 1	2	3	4	5	
It is my responsibility to make other people happy	1	2	3	4	5
I should strive for perfection	1	2	3	4	5
Basically, there are two ways of doing things — the right way and the wrong way	1	2	3	4	5

Expectations regarding therapy:

In a few words, what do you think therapy is all about?

How long do you think your therapy should last?

How do you think a therapist should interact with his or her clients?

What personal qualities do you think the ideal therapist should possess?

Please complete the following:

I am a person who

All my life

Ever since I was a child

It's hard for me to admit

One of the things I can't forgive is

A good thing about having problems is

The bad thing about growing up is

One of the ways I could help myself but don't is

9. INTERPERSONAL RELATIONSHIPS

A. Family of Origin

(1) If you were not brought up by your parents, who raised you and between what years?

(2) Give a description of your father's (or father substitute's) personality and his attitude toward you (past and present).

(3) Give a description of your mother's (or mother substitute's) personality and her attitude toward you (past and present).

(4) In what ways were you disciplined (punished) by your parents as a child?

(5) Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and between children.

(6) Were you able to confide in your parents?

(7) Did your parents understand you?

(8) Basically, did you feel loved and respected by your parents?

(9) If you have a stepparent, give your age when parent remarried.

(10) Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.)?

(11) Who are the most important people in your life?

B. Friendships

(1) Do you make friends easily?
(2) Do you keep them?
(3) Were you ever bullied or severely teased?
(4) Describe any relationship that gives you:
(a) Joy

(b) Grief

(5) Rate the degree to which you generally feel comfortable and relaxed in social situations?
Very relaxed_____
Relatively comfortable_____
Relatively uncomfortable_____
Very anxious_____

(6) Generally, do you express your feelings, opinions, and wishes to others in an open, appropriate manner?

Describe those individuals with whom (or those situations in which) you have trouble asserting yourself.

(7) Did you date much during high school? College?

(8) Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings?

C. Marriage

(1) How long did you know your spouse before your engagement?
(2) How long have you been married?
(3) What is your spouse's age?
(4) What is your spouse's occupation?
(5) Describe your spouse's personality.

(6) In what areas are you compatible?

(7) In what areas are you incompatible?

(8) How do you get along with your in-laws (this includes brothers and sisters-in law)?

(9) How many children do you have?
Please give their names, ages and sexes.

(10) Do any of your children present special problems? If so, elaborate.

(11) Any relevant information regarding abortions or miscarriages?

D. Sexual Relationships:

(1) Describe your parents' attitude toward sex. Was sex discussed in your home?

(2) When and how did you derive your first knowledge of sex?

(3) When did you first become aware of your own sexual impulses?

(4) Have you ever experienced any anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain.

(5) Any relevant details regarding your first or subsequent sexual experiences?

(6) Is your present sex life satisfactory? If not, please explain.

(7) Provide information about any significant homosexual reactions or relationships.

(8) Please note any sexual concerns not discussed above.

E. Other relationships:

(1) Are there any problems in your relationships with people at work? If so, describe.

(2) Please complete the following:

(a) One of the ways people hurt me is

(b) I could shock you by

(c) A mother should

(d) A father should

(e) A true friend should

(3) Give a brief description of yourself as you would be described by:

(a) Your spouse (if married)

(b) Your best friend

(c) Someone who dislikes you

(4) Are you currently troubled by any past rejections or loss of a love relationship? If so, please explain.

10. BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Please specify.

Please list any medicines you are currently taking, or have taken during the past six months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter):

Do you eat three well-balanced meals each day? If not, please explain.

Do you get regular physical exercise? If so, what type and how often?

Underline any of the following that apply to you or members of your family:

thyroid disease, kidney disease, asthma, neurological disease, infectious diseases, diabetes, cancer, gastrointestinal disease, prostate problems, glaucoma, epilepsy, other:

Have you ever had any head injuries or loss of consciousness? Please give details:

Please describe any surgery you have had (give dates).

Please describe any accidents or injuries you have suffered (give dates).

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often
Marijuana	1	2	3	4
Tranquilizers	1	2	3	4
Sedatives	1	2	3	4
Aspirin	1	2	3	4
Cocaine	1	2	3	4
Painkillers	1	2	3	4
Alcohol	1	2	3	4
Coffee	1	2	3	4
Cigarettes	1	2	3	4
Narcotics	1	2	3	4
Stimulants	1	2	3	4
Hallucinogen (LSD, etc.)	1	2	3	4
Diarrhea	1	2	3	4
Constipation	1	2	3	4
Allergies	1	2	3	4
High blood pressure	1	2	3	4
Heart problems	1	2	3	4
Nausea	1	2	3	4
Vomiting	1	2	3	4
Insomnia	1	2	3	4
Headaches	1	2	3	4
Backache	1	2	3	4
Early morning awakening	1	2	3	4
Fitful sleep	1	2	3	4
Overeat	1	2	3	4
Poor appetite	1	2	3	4
Eat “junk food”	1	2	3	4

SEQUENTIAL HISTORY

Please outline your most significant memories and experiences within the following ages.
(use additional paper if necessary)

0 - 5

6 - 10

11 - 15

16 - 20

21 - 25

26 - 30

31 - 35

36 - 40

41 - 45

46 - 50

51 - 55

56 - 60

61 - 65

Over 65