Life History Questionnaire

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GENERAL INFORMATION

Date:__________________

Name:____

Address:____

Telephone numbers: Day________________________________Evening______________________________

Age:____________ Occupation:____ Sex:___M ___F

Date of birth:_____________ Place of birth____________________________ Religion:_________________

Height:______Weight:_______ Does your weight fluctuate? ____Yes ____No If yes, by how much?_______

Do you have a family physician? _____Yes _____No

Name of family physician:_____________________________________ Telephone number:______________

By whom were you referred?____

Marital status (check one): ___Single ___Engaged ___Married ___Separated ___Divorced ___Widowed
___Living with someone ___Remarried: How many times?____________________________________

Do you live in: ____House ____Room ____Apartment ____Other:_________________________________

With whom do you live? (check all that apply): ____Self ____Parents ____Spouse ____Roommate
___Children ___Friend(s) ___Others (specify):____

What sort of work are you doing now?____

Does your present work satisfy you? ____Yes ____No

If no, please explain: ____
____

What kind of jobs have you held in the past?____
____

Have you been in therapy before or received any professional assistance for your problems? ___Yes ___No

Have you ever been hospitalized for psychological/psychiatric problems? ___Yes ___No

If yes, when and where?____

____

Have you ever attempted suicide? ___Yes ___No

Does any member of your family suffer from an “emotional” or “mental disorder”? ___Yes ___No

Has any relative attempted or committed suicide? ___Yes ___No

PERSONAL AND SOCIAL HISTORY

Father: Name:____ Age:__________

Occupation:______________________________________ Health:_______________

If deceased, give his age at time of death:________How old were you at this time?____________

Cause of death:____

Mother: Name:____ Age:__________

Occupation:______________________________________ Health:_______________

If deceased, give her age at time of death:________How old were you at this time?____________

Cause of death:____

Siblings: Age(s) of brother(s):______________________Age(s) of sister(s):_____________________

Any significant details about siblings:____

____

____

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

____

____

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

____

____

____

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

____

____

____

In what ways were you disciplined or punished by your parents?______________________________________

____

____

____

____

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.

____

____

____

____

____

____

Were you able to confide in your parents? ____Yes ____No
Basically, did you feel loved and respected by your parents? ____Yes ____No
If you have a stepparent, give your age when your parents married:_____________________________
Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.? ___Yes ___No

If yes, please describe briefly:____

____

____

Scholastic strengths:____

Scholastic weaknesses:____

What was the last grade completed (or highest degree)?____________________________

Check any of the following that applied during your childhood/adolescence:

___Happy childhood
___Unhappy childhood
___Emotional/behavioral problems
___Legal trouble
___Death in family
___Medical problems
___Ignored
___Not enough friends
___School problems
___Financial problems
___Strong religious convictions
___Drug use
___Used alcohol
___Severely punished
___Sexually abused
___Severely bullied/teased
___Eating disorder
___Others:______________
____
____
____

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problems:_______________________________________

____

____

____

____

____

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 problems begin?____

____

What seems to worsen your problems?____

____

What have you tried that has been helpful?____

____

How satisfied are you with your life as a whole these days?

Not at all satisfied 1 2 3 4 5 6 7 Very satisfied

How would you rate your overall level of tension during the past month?

Relaxed 1 2 3 4 5 6 7 Tense

EXPECTATIONS REGARDING THERAPY

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

____

____

How long do you think your therapy should last?____

____

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

____

____

MODALITY ANALYSIS OF CURRENT PROBLEMS

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable me to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven modalities of Behavior, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships, and Biological Factors.

BEHAVIORS

Check any of the following behavior that often apply to you:

___Overeat
___Take drugs
___Unassertive
___Odd behavior
___Drink too much
___Work too hard
___Procrastination
___Sleep disturbance

___Loss of control
___Suicidal attempts
___Compulsions
___Smoke
___Withdrawal
___Nervous tics
___Concentration difficulties
___Impulsive reactions

___Phobic avoidance
___Spend too much money
___Can't keep a job
___Insomnia
___Take too many risks
___Lazy
___Eating problems
___Aggressive behavior

___Crying
___Outbursts of Temper
___Other________
____
____
____

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

____

What would you like to start doing?____

____

What would you like to stop doing?____

____

How is your free time spent?____

____

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

____

Do you have trouble relaxing or enjoying weekends and vacations? ____Yes ____No

If yes, please explain:____

____

____

If you could have any two wishes, what would they be?_______________________________________

____

FEELINGS

___Angry	___Fearful	___Happy	___Hopeful	___Bored	___Optimistic
___Annoyed	___Panicky	___Conflicted	___Helpless	___Restless	___Tense
___Sad	___Energetic	___Shameful	___Relaxed	___Lonely	___Others:________________
___Depressed	___Envious	___Regretful	___Jealous	___Contented	____________________
___Anxious	___Guilty	___Hopeless	___Unhappy	___Excited	____________________

List your five main fears:

1.____

2.____

3.____

4.____

5.____

What are some positive feelings you have experienced recently?_______________________________

____

____

Describe any situations that make you feel calm or relaxed:__________________________________

____

____

PHYSICAL SENSATIONS

Check any of the following physical sensations that often apply to you:

___Abdominal pain	___Bowel disturbances	___Hear things	___Blackouts
___Pain or burning with urination	___Tingling	___Watery eyes	___Excessive sweating
___Menstrual difficulties	___Numbness	___Flushes	___Visual disturbances
___Headaches	___Stomach trouble	___Nausea	___Hearing problems
___Dizziness	___Tics	___Skin problems	___ Others:_________
___Palpitations	___Fatigue	___Dry mouth	______________
___Muscle spasms	___Twitches	___Burning/itching skin	______________
___Tension	___Back pain	___Chest pains	
___Sexual disturbances	___Tremors	___Rapid heartbeat	
___Unable to relax	___Fainting spells	___Don’t like to be touched	

What sensations are:

Pleasant for you?____

Unpleasant for you?____

IMAGES

Check any of the following that apply to you:

I picture myself:

___Being happy
___Being hurt
___Not coping
___Succeeding
___Losing control
___Being followed
___Being talked about
___Being aggressive
___Being helpless
___Hurting others
___Being in charge
___Failing
___Being trapped
___Being laughed at
___Being promiscuous
___Others:______________
____
____

I have:

___Pleasant sexual images
___Images of being loved
___Unpleasant sexual images
___Seduction images
___Negative body image
___Lonely images
___Unpleasant childhood images
___Others:______________
____

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":____________________________

____

____

Describe any persistent or disturbing images that interfere with your daily functioning:__________

____

____

How often do you have nightmare?_______________________________________

THOUGHTS

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

___Intelligent ___A nobody ___Inadequate ___Concentration difficulties
___Lazy ___Confident ___Useless ___Confused ___Untrustworthy
___Memory problems ___Worthwhile ___Evil ___Ugly ___Attractive
___Dishonest ___Ambitious ___Crazy ___Stupid ___Sensitive
___Can't make decisions ___Morally degenerate ___Naïve ___Suicidal ideas
___Loyal ___Considerate ___Honest ___Persevering ___Others:________
___Trustworthy ___Deviant ___Incompetent ___Unattractive ___________
___Good sense of humor ___Full of regrets ___Horrible thoughts ___________
___Hard working ___Worthless ___Unlovable ___Conflicted ___Undesirable

What do you consider to be your craziest thought or idea?_______________________________________

____

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

If yes, what are these thoughts?____

____

What worries do you have that may negatively affect your mood or behavior?______________________

____

On each of the following items, please 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 something, 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
I should never be upset	1	2	3	4	5

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? ___Yes ___No Do you keep them? ___Yes ___No
Did you date much during high school? ___Yes ___No College? ___Yes ___No
Were you ever bullied or severely teased? ___Yes ___No

Describe any relationship that gives you:

Joy:____

____

Grief:____

____

Rate the degree to which you generally feel relaxed and comfortable in social situations:
Very relaxed 1 2 3 4 5 6 7 Very anxious
Do you have one or more friends with whom you feel comfortable sharing your most private thoughts?
___Yes ___No

Marriage (or committed relationship)

How long did you know your spouse before you engagement?______________________________
How long were you engaged before you got married?___________________________________
How long have you been married?____
What is your spouse's age?_______His/her occupation?_________________________________

Describe your spouse's personality:____

____

____

What do you like most about your spouse?____

____

____

What do you like least about your spouse?____

____

____

What factors detract from your marital satisfaction?___________________________________

____

On the scale below, please indicate how satisfied are you with you marriage:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your partner's friends and family?

Very poorly 1 2 3 4 5 6 7 Very well

How many children do you have?____

Please give their names and ages:____

____

____

Do any of your children present special problems? ___Yes ___No

If yes, please describe:____

____

Any significant details about a previous marriage(s)?__________________________________

____

____

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home?__________________

____

When and how did you derive your first knowledge of sex?______________________________

____

____

When did you first become aware of your own sexual impulses?___________________________

____

____

Have your ever experienced any anxiety or guilt arising out of sex or masturbation? ___Yes ___No

If yes, please explain:____

____

Any relevant details regarding your first or subsequent sexual experienced?__________________

____

Is your present sex life satisfactory? ___Yes ___No

If no, please explain:____

____

____

Provide information about any significant homosexual reactions or relationships:________________________

____

____

Please note any sexual concerns not discussed above:______________________________________

____

____

Other Relationships

Are there any problems in your relationships with people at work? ___Yes ___No

If yes, please describe:____

____

Please complete the following:

One of the ways people hurt me is:____

____

I could shock you by:____

____

My spouse (or boyfriend/girlfriend) would describe me as:______________________________________

____

My best friend thinks I am:____

____

People who dislike me:____

____

Are you currently troubled by any past rejections or loss of a love relationship? ___Yes ___No

If yes, please explain:____

____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? ___Yes ___No

If yes, please specify:____

____

____

____

Please list any medications you are currently taking:_____________________________________

____

____

Do you eat three well-balanced meals each day? ___Yes ___No
Do you get regular physical exercise? ___Yes ___No

If yes, what type and how often?____

____

____

Please list any significant medical problems that apply to you or to members of your family:__________

____

____

____

Please describe any surgery you have had (give dates):____________________________________

____

____

Please describe any physical handicap(s) you have:_______________________________________

____

____

Menstrual History

Age at first period:_____Were you informed?___Yes ___No Did it come as a shock? ___Yes ___No
Are you regular? ___Yes ___No Duration:____________________ Do you have pain?___Yes ___No
Do your periods affect your moods? ___Yes ___No Date of last period:_______________________

	Never	Rarely	Occasionally	Frequently	Daily
Muscle weakness					
Tranquilizers					
Diuretics					
Diet Pills					
Marijuana					
Hormones					
Sleeping pills					
Aspirin					
Cocaine					
Pain killers					
Narcotics					
Stimulants					
Hallucinogens (e.g., LSD)					
Laxatives					
Cigarettes					
Tobacco (specify)					
Coffee					
Alcohol					
Birth control pills					
Vitamins					
Undereat					
Overeat					
Eat junk foods					
Diarrhea					
Constipation					
Gas					
Indigestion					
Nausea					
Vomiting					
Heartburn					
Dizziness					
Palpitations					
Fatigue					
Allergies					
High blood pressure					
Chest pain					
Shortness of breath					
Insomnia					
Sleep too much					
Early morning awakening					
Earaches					
Headaches					
Backaches					
Bruise or bleed easily					
Weight problems					
Others:					

STRUCTURAL PROFILE

Directions: Rate yourself on the following dimensions on a seven-point scale with "1" being the lowest And "7" being the highest.

BEHAVIORS:	Some people may be described as "doers" – they are action oriented, they like to busy themselves, get things done, take on various projects. How much of a doer are you?	1 2 3 4 5 6 7
FEELINGS:	Some people are very emotional and may or may not express it. How emotional are you? How deeply do you feel things? Ho passionate are you?	1 2 3 4 5 6 7
PHYSICAL SENSATIONS:	Some people attach a lot of value to sensory experiences, such sex, food, music, art, and other "sensory delights." Others are very much aware of minor aches, pains, and discomforts. How "tuned into" your sensations are you?	1 2 3 4 5 6 7
MENTAL IMAGES	How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is "thinking in pictures," visualizing real or imagined experiences, letting your mind roam. How much are you into imagery?	1 2 3 4 5 6 7
THOUGHTS	Some people are very analytical and like to plan things. They Like to reason things through. How much of a "thinker" and "planner" are you?	1 2 3 4 5 6 7
INTERPERSONAL RELATIONSHIPS:	How important are other people to you? This is your self-rating as a social being. How important are close friendships to you, the tendency to gravitate toward people, the desire for intimacy? The opposite of being a "loner."	1 2 3 4 5 6 7
BIOLOGICAL FACTORS:	Are you healthy and health conscious? Do you avoid bad habits like smoking, too much alcohol, drinking a lot of coffee, overeating, etc.? Do you exercise regularly, get enough sleep, avoid junk foods, and generally take care of your body?	1 2 3 4 5 6 7

Please describe any significant childhood (or other) memories and experiences you think your therapist should be aware of: