

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your life experience and background. Completing these questions as fully and as accurately as you can will benefit you through the development of a treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Date _____/_____/_____

Name _____

Address _____

Telephone numbers (day) _____ (evenings) _____

DOB _____/_____/_____ Age _____ Occupation _____

By who were you referred? _____

With whom are you now living? (list people)

Where do you reside? __house __hotel __room __apartment __other

Significant relationship status (check one):

single

engaged

married

separated

divorced

remarried

committed relationship

widowed

If married, husband's (or wife's) name, age, occupation?

1. Role of religion and/or spirituality in your life:

In childhood _____

As an adult _____

2. Clinical

A. State in your own words the nature of your main problems and how long they have been present:

B. Give a brief history and development of your complaints (from onset to present):

C. On the scale below please check the severity of your problem(s):

- mildly upsetting
- moderately severe
- very severe
- extremely severe
- totally incapacitating

D. Whom have you previously consulted about your present problem(s)?

E. Are you taking any medication? If "yes", what, how much, and with what results?

3. Personal Data

A. Date of Birth ____/____/____ Place of birth _____

B. Mother's condition during pregnancy (as far as you know): _____

C. Check any of the following that applied during your childhood:

- | | | |
|--|--|--|
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Stammering |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Happy childhood | <input type="checkbox"/> Unhappy childhood |

Any others: _____

D. Health during childhood?

List illnesses:

E. Health during adolescence?

List illnesses

F. What is your height: _____ Your weight _____

G. Any surgical operations? (Please list them and give age at the time)

H. Any accidents:

I. List your five main fears:

1. _____
2. _____
3. _____
4. _____
5. _____

J. Underline any of the following that apply to you:

Headaches	Dizziness	Fainting spells
Palpitations	Stomach trouble	Anxiety
Bowel disturbances	Fatigue	No appetite
Anger	Take sedatives	Insomnia
Nightmares	Feel panicky	Alcoholism
Feel tense	Conflict	Tremors
Depressed	Suicidal ideas	Take Drugs
Unable to relax	Sexual problems	Allergies
Don't like weekends and vacations	Overambitious	Shy with people
Can't make friends	Inferiority feelings	Can't make decisions
Can't keep a job	Memory problems	Home conditions bad
Financial problems	Lonely	Unable to have a good time
Excessive sweating	Often use aspirin or painkillers	Concentration difficulties

Please list additional problems or difficulties here.

K. Circle any of the following words which apply to you:

Worthless, useless, a "nobody," "life is empty", inadequate, stupid, incompetent, naïve, "can't do anything right", guilty, evil, morally wrong, horrible thoughts, hostile, full of hate, anxious, agitated, cowardly, unassertive, panicky, aggressive ugly, deformed, unattractive, repulsive, depressed, lonely, misunderstood, bored, restless, confused, unconfident, in conflict, full of regrets, worthwhile, sympathetic, intelligent, attractive, confident, considerate.

Please list any additional words:

L. Present interest, hobbies, and activities _____

M. How is most of your free time occupied? _____

N. What is the last grade of school that you completed? _____

O. Scholastic abilities: strengths and weaknesses

P. Were you ever bullied or severely teased? _____

Q. Do you make friends easily? _____

4. Occupational Data

A. What sort of work are you doing now?

B. List previous jobs.

C. Does your present work satisfy you? (If not, in what ways are you dissatisfied?)

D. How much do you earn? _____

How much does it cost you to live? _____

E. Ambitions/Goals _____

Past _____

Present _____

5. Sex Information

A. Parental attitudes toward sex (e.g., was there sex instruction or discussion in the home?)

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

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

D. Did you ever experience any anxieties or guilt feelings arising out of sex or masturbation? If "yes," please explain.

E. Please list any relevant details regarding your first or subsequent sexual experience.

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

G. Provide information about any significant heterosexual (and/or homosexual) reactions.

H. Are you sexually inhibited in any way? _____

6. Menstrual History

Age of first period? _____

Were you informed or did it come as a shock? _____

Are you regular? _____ Duration _____

Do you have pain? _____ Date of last period _____

Do your periods affect your moods? _____

7. Marital History

How long did you know your marriage partner before engagement? _____

How long have you been married? _____

Husband's/Wife's age _____

Occupation of husband or wife _____

A. Describe the personality of your husband or wife (in your own words)

B. In what areas is there compatibility?

C. In what areas is there incompatibility?

D. How do you get along with your in-laws? (This includes brothers and sisters-in-law.)

E. Do any of your children present special problems?

F. Any history of miscarriages or abortions?

G. Comments about any previous marriage(s) and brief details.

8. Family Data

A. *Father*
Living or deceased? _____

If deceased, your age at the time of his death. _____

Cause of death. _____

If alive, father's present age. _____

Occupation: _____

Health: _____

B. Mother

Living or deceased? _____

If deceased, your age at the time of her death. _____

Cause of death. _____

If alive, mother's present age. _____

Occupation: _____

Health: _____

C. Siblings

Number of brothers: _____ Brothers' ages: _____

Number of sisters: _____ Sisters' ages: _____

D. Relationship with brothers and sisters:

Past: _____

Present: _____

E. Give a description of your father's personality and his attitude toward you (past and present):

F. Give a description of your father's personality and his attitude toward you (past and present):

G. In what ways were you punished by your parents as a child?

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

I. Were you able to confide in your parents? _____

J. Did your parents understand you? _____

K. Basically, did you feel loved and respected by your parents? _____

If you have a step-parent, give your age when parent remarried: _____

L. Describe your religious training:

M. If you were not raised by your parents, who did raise you, and between what years?

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

O. Who are the most important people in your life?

P. Does any member of your family suffer from alcoholism, epilepsy, or anything, which can be considered a "mental disorder"?

Q. Are there any other members of the family about whom information regarding illness, etc., is relevant?

R. Recount any fearful or distressing experiences not previously mentioned?

S. What do you expect to accomplish from therapy, and how long do you expect therapy to last?

T. List any situations, which make you feel calm or relaxed.

U. Have you ever lost control (e.g., temper or crying or aggression)? If so, please describe.

V. Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you.

9. Self-Description (Please complete the following):

A. I am a person who _____

- B. All my life _____
- C. Ever since I was a child _____
- D. One of the things I feel proud of is _____
- E. One of the things I can't forgive is _____
- F. One of the things I can't forgive is _____
- G. One of the things I feel guilty about is _____
- H. If I didn't have to worry about my image _____
- I. One of the ways people hurt me is _____
- J. Mother was always _____
- K. What I needed from mother and didn't get was _____
- L. Father was always _____
- M. What I wanted from my father and didn't get was _____
- N. If I weren't afraid to be myself, I might _____
- O. One of the things I'm angry about is _____
- P. What I need and have never received from a woman (man) is _____
-
- Q. The bad thing about growing up is _____
- R. One of the ways I could help myself but don't is _____
-

10.

- A. What is there about your present *behavior* that you would like to change?
- B. What feelings do you wish to alter (e.g., increase or decrease)?
- C. What sensations are especially:
1. pleasant for you?
 2. unpleasant for you?
- D. Describe a very pleasant image of fantasy.
- E. Describe a very unpleasant image of fantasy.

- F. What do you consider your most irrational thought or idea?

- G. Describe any interpersonal relationships that give you:
 - 1. joy
 - 2. grief

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

With the remaining space and blank sides of these pages, give a brief description of you by the following people.

- A. Yourself
- B. Your spouse (if married)
- C. Your best friend
- D. Someone who dislikes you