# 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 accurately as possible will benefit you through the development of a treatment plan suited to your specific needs. Please return this questionnaire on your next visit for review and discussion.

**PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES**

Name:_____ Date: _____

What do you want to gain from therapy?

_____

_____

What is the role of religion and/or spirituality in your life:_____

_ _ _ _ _ _ _____

_ __ __ _ __ _ **Check any of the following that applied during your childhood:**

☐ Night Terrors ☐ Bedwetting ☐ Sleepwalking ☐ Irrational Fears
☐ Thumb Sucking ☐ Nail Biting ☐ Nervous Behavior ☐ Hair Pulling
☐ Happy Childhood ☐ Unhappy Childhood ☐ Rational Fears ☐ Aggression

What was your health condition during childhood?
☐ Healthy ☐ Normal illnesses
☐ Abnormal Illnesses(list)_____

Health condition during adolescence?
☐ Healthy ☐ Normal Illnesses
☐ Abnormal Illnesses(List) _____

Health Condition currently?
☐ Healthy ☐ Normal Illness:_____
☐ Abnormal Illness (List) _____

Any past surgeries? ☐ No ☐ Yes: (when and what kind?)

_____

Any accidents? ☐ No ☐ Yes
(explain)_____

_____

**Please list your five main fears:**

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

**CIRCLE any of the following that apply to you:**

| | | | | |
|---|---|---|---|---|
| Headaches | Dizziness | Fainting Spells | Palpitations | Stomach Trouble |
| Anxiety | Anger | Insomnia | Nightmares | Bowel Problems |
| Fatigue | No appetite | Alcoholism | Feel Tense | Take Sedatives |
| Conflict | Tremors | Depressed | Drug Use | Suicidal Ideas |
| Can't Relax | Allergies | Shyness | Feel Inferior | Don't like "fun" activity |
| Can't keep job | Overambitious | Lonely | Poor memory | Poor Concentration |
| Excessive Sweating | | Can't make decisions | | Unable to have a good time |
| Bad Home Conditions | | Often use aspirin or painkillers | | |

**CIRCLE any of the following words which apply to you:**

| | | | | | |
|---|---|---|---|---|---|
| Worthless | Useless | "nobody" | "Life is empty" | Inadequate | Unsafe |
| Stupid | incompetent | naïve | guilty | evil | hostile |
| "cant do anything right" | | morally wrong | horrible thoughts | | full of hate |
| Anxious | agitated | cowardly | unassertive | panicky | aggressive |
| Ugly | deformed | unattractive | repulsive | depressed | lonely |
| Unloved | unconfident | in conflict | full of regrets | worthwhile | sympathetic |
| Intelligent | attractive | confident | considerate | adequate | safe |

Current interests, hobbies, activities: _____
_____

How do you spend your free time?_____
_____

Any past or current Legal Problems? ☐ No ☐ Yes (explain)_____
_____

Any current Financial Problems? ☐ No ☐ Yes (explain)_____
_____

Any current drug or alcohol use problem? ☐ No ☐ Yes (include Nicotine/Caffeine):

| **Substance Used:** | **How Often?** | **How used?** | **Problem?** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Any Family History of Drug/Alcohol Problems? (explain) _____
_____

**Any current general Life problems? Check all that apply:**
☐ Sexual issues ☐ Marriage Stress
☐ Relational Problems (other than marriage/family)
☐ Family Issues (explain) _____
☐ Grief and/or Loss issues ☐ General health stress
☐ Aggression toward others ☐ Anger Management problems ☐ Self Esteem
☐ Occupational Stress (explain) _____
Other:_____

Is there anything about your present *behavior* that you would like to change? ☐ No ☐ Yes (explain): _____
_____
_____

Any Current Sleep Problems? ☐ No ☐ Yes (explain) _____

Any specific current appetite concern?_____

Any recent lifestyle changes? ☐ No ☐ Yes (explain): _____
_____
_____

Describe your friends: _____
_____

How satisfied are you in your current friendships?
_____

Describe your Spouse or Partner: _____
_____

How satisfied are you in your Marriage/Intimate Relationship?
_____
_____

What do you see as your current strengths as a person? _____
_____

What do you see as your general struggles? _____
_____

Does Suicide ever become an option for you? ☐ No ☐ Yes (explain) _____
_____

Any past or current suicidal thoughts or attempts? ☐ No ☐ Yes:
When and what happened?_____
_____
_____

Does Homicide ever become an option for you? ☐ No ☐ Yes (explain) _____
_____

Any past or current homicidal thoughts or attempts? ☐ No ☐ Yes:
When and what happened?_____
_____
_____

What do you consider your most irrational thought or fear? _____
_____

How do you feel inside ***most*** of the time? _____

What feelings do you want to alter (either increase or decrease)? _____
_____

**Any past Trauma or Abuse during your life time?** ☐ No ☐ Yes (explain):
☐ Physical Abuse _____
☐ Emotional Abuse_____
☐ Sexual Abuse:_____
☐ Neglect/Abandonment: _____

What are you willing to do to help with therapy? _____
_____

What do you want from your therapist to help with your desired change? _____
_____

I'll know that therapy was successful when: _____
_____

Is there any other information that you want your therapist to know? _____
_____
_____