LIFE HISTORY QUESTIONNAIRE

Date: ______________________________

Name: ____

Home Address: ____
____
____
City Postal Code

Ways to contact you	OK to leave messages? (yes or no)
Home Phone #:	
Cell Phone #:	
Work Phone #:	
E-mail address:	

Date of Birth: _______ _______ ________
Month Day Year

Marital Status: _____________________________________

Number of Children: _____ Age (s): ________________

Occupation (present or most recent): ____

Employer: ____

Family Physician: Dr. ___________________________ Phone # : (______)_________________

When was your last medical examination? ___________________ ___________________
Month Year

Who referred you to us? Where did you find our number?
____
____

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Reason(s) for Consultation

1A- What is/are the problem (s) you would like help with?

____
____
____
____
____

1B- When did this difficulty begin? What was going on in your life?

____
____
____
____
____

1C- Were there periods in the past when the problem got significantly better or worst? What made the problem worst, or what helped improve things?

____
____
____
____
____

1D- How do you explain what is going on with your life?

____
____
____
____
____

1E- What are your expectations for therapy?

____
____
____
____
____

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History of Psychological Difficulties

2A- Have you ever been very anxious? Yes No
If so, tell us about it:

2B- Have you ever had a problem with anger or aggression? Yes No
If so, tell us about it:

2C- Have you ever been depressed? Yes No
If so, tell us about it:

2D- Have you ever contemplated suicide or thought about hurting yourself? Yes No
If so, please explain:

2E- Have you ever tried to commit suicide? Yes No
If so, please explain:

2F- Do you currently have any suicidal ideas? Yes No
If so, please explain:

2G- What helped you cope with your sadness or depression in the past?

2H- Tell us about any relationship problems you may be experiencing:

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2I- Tell us about any problems you might have had in childhood, while growing up:

2J- Tell us about any work or academic problems you may be experiencing:

2K- Tell us about any current financial stresses. (eg. accumulating bills, family debts etc.)

2L- Have you ever experienced a serious trauma (physical or psychological)? The trauma could be something that occurred once (such as a traffic accident) or repeatedly (perhaps like sexual abuse). If yes, please give dates and describe:

2M- Are there any mental illnesses or alcohol problems in your family? Yes No
If so, please describe:

2N- Are there any other problems bothering you at the present time? Yes No
If so, please describe:

History of Seeking Help

Tell us about the mental health professionals you might have consulted in the past (approximate dates, length of treatment, type of professional seen, description of problem, nature of treatment).

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Medical History

Please list any current medical conditions and treatments

Current Condition	Treatment(s) including medication, operations etc.

List any past medical conditions and treatments

Past Condition	Treatment(s) including medication, operations etc.

Please list all medications you are taking, including vitamins, herbal remedies or over the counter drugs

Medication	Dosage (mg)	For what problem?

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Exercise

Physical activities	Times per week

Sleep

How many hours of sleep do you currently get per night? __________
Are you satisfied with this amount of sleep? Yes No
Any changes in this amount recently? Yes No

Do you have difficulties falling asleep? Yes No
Do you have difficulties remaining asleep? Yes No
Do you have difficulties waking up too early? Yes No
Do you have difficulties remaining awake during the day? Yes No

If yes to any, please explain
____
____
____

Consumption Habits

Please describe any problems in your eating habits. (eg. excessive eating when stressed; lack of appetite, repetitive dieting, etc.)
____
____
____

Approximately how many times do you drink alcohol on a weekly basis? ________________________
On average, how many alcoholic beverages do you drink per occasion? ________________________

Approximately how many cigarettes do you smoke on a daily basis? ___________________________
Have you ever tried to stop smoking? Yes No
If so, when was your last attempt at quitting? ____

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Recreational drug use (eg marijuana, cocaine, etc.)

Substance	Amount/Frequency (eg. one joint per month)

Have you ever thought you might have a drug or alcohol problem (currently or in the past), or has anyone around you considered that you might have had a problem? Yes No
If so, please describe:

___

___

___

Social Functioning

	Number	Comments
How many friendly contacts do you have ***outside of work/school***?		
How many friendly contacts do you have ***at work/school***?		
How many close and supportive relationships do you have including family, friends, and co-workers?		

In general, how would you describe the way you get along with people:

Education
Please tell us about your academic history, including year of graduation(s), degree(s), and program of study.

Future
Tell us about your plans for the future (career, personal, etc.):

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