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Life History Questionnaire

Personal Information

Name: _____

Date: _____

Address: _____

Phone: _____

Email: _____

Date of Birth: _____

Marital Status: _____

Presenting Problem:

_____

_____

_____

Presenting Symptoms: (Please circle)

Depressed Mood	Guilt	Racing Thoughts	Restlessness
Decreased Energy	Worthlessness	Irritability	Grief
Physical Issues	Anxiousness	Hopelessness	Impulsiveness
Marital Conflict	Family Problems	Work Problems	School Issues

Life Changes/Stressors:

_____

_____

_____

Have you previously received any type of mental health services (therapy or psychiatric services)?

_____

_____

_____

Family Psychiatric History (please circle):

		List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Medical Conditions & History:

_____

_____

_____

Current Medications (dosage, purpose, prescribing physician):

_____

_____

_____

Health/Lifestyle

Rate your current physical health (please circle): Poor Unsatisfactory Satisfactory Good Very Good

Rate your current sleeping habits (please circle): Poor Unsatisfactory Satisfactory Good Very Good

List any difficulties you experience with your appetite or eating:

_____

How many times per day do you consume caffeine?

_____

How often do you smoke or vape nicotine?

_____

How many times per week do you exercise and what type of exercise?

_____

Please list how often you engage in recreational drug use and/or drink alcohol per week:

_____

Social History (significant relationships, social support):

_____

_____

_____

Educational History (include school name, date of graduation, and field of study for higher education):

_____

_____

_____

Occupational History (current and past employment):

_____

_____

_____

Legal History (arrest history, sentencing, DUI, incarceration, litigation, bankruptcy):

_____

Spiritual/Religious (include beliefs, spiritual orientation)

_____

Additional Information

What do you consider your strengths?

_____

_____

_____

What do you consider your limitations?

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____