

Dr Laura Lehmann, PLLC

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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?
