

LIFE HISTORY QUESTIONNAIRE

Client's Name: _____ Birth Date: _____
Today's Date: _____

Gender: male female Marital Status: Married Single Divorced Separated

Client's address: _____ Home Phone: _____
_____ Cell Phone: _____
_____ Work Phone: _____

Age: _____ Occupation: _____

Highest grade completed: _____ Ethnicity/Race: _____

Height: _____ Weight: _____ Corrective Lenses? _____ Hearing Aid? _____

Disabilities? _____

Present concerns/reasons you are seeking services? _____

When did this start to be a concern? _____

Who referred you to this clinic? _____

Physician Social Worker Therapist other _____

Family Background:

Spouse's Name (if applicable): _____ Date of marriage: _____

Age: _____ Occupation: _____

Highest Grade Completed: _____ Ethnicity/Race: _____

Other Individuals Living in Family Home:

Age	Gender	First Name	Relationship (daughter, son, grandparent, etc.)

Are your parents still living? Yes No

Mother's Name: _____ Age: _____

Occupation: _____ City/State of Residence: _____

Father Name: _____ Age: _____

Occupation: _____ City/State of Residence: _____

Please list your brothers and sisters:

Age	Gender	First Name	Relationship (brother, sister, step-sister, step-brother)

Medical History:

Physician's name: _____

Clinic and address: _____

Please list any hospitalizations, serious illnesses, or surgeries that you have had and indicate age:

Other medical concerns? _____

Do you wear corrective lenses? Yes No

Which hand do you use for writing or drawing? Right Left

Are you currently on medication? Yes No (if yes, please indicate below type and dosage)

Name of medication	Dosage	Date first prescribed	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you received previous mental health services? No Yes (If yes, please describe below)

Type of services and concern	Provider/Facility	Dates of Service

Is there any history of the following problems? If yes, please describe.

- Learning difficulties: _____
- Speech difficulties _____
- Underweight or overweight problem _____
- Fever greater than 105°F _____
- Allergies/asthma _____
- Eating problems _____
- Deficits in motor skills _____
- Excessive crying _____
- Head injuries/loss of consciousness _____
- Seizures _____
- Hearing problems _____
- Vision problems _____

Have you experienced any of the following?

- Physical abuse _____
- Sexual abuse _____
- Verbal/emotional abuse _____
- Exposure to domestic violence abuse _____

Are you involved in any legal issues? _____

Family history of mental health problems (for example, depression, learning difficulties, ADHD, anxiety, alcoholism, mental retardation, schizophrenia, bipolar disorder, etc.): _____

Education History:

High School: _____ GPA: _____

College: _____ Major: _____

Did you ever receive special education services: Yes No If yes, when? _____**Work History:**

Dates of Employment	Employer	Job Title/Duties

Alcohol/Drug Use:

Describe your current use of alcohol or non-prescription drugs: _____

When did you first begin to use alcohol/drugs (if applicable): _____

Have you ever received treatment for chemical use? _____

Lifestyle Habits:

Do you have any sleep difficulties? _____

What is your current use of caffeine? _____

What time do you go to bed? _____

How long does it usually take for you to fall asleep? _____

Do you wake during the night? _____

How many hours of sleep do you typically get at night? _____

How many days per week do you engage in at least 30 minutes of exercise? _____

Additional Comments: