# 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.) |
|---|---|---|---|
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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) |
|---|---|---|---|
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**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 |
|---|---|---|
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| | | |
| | | |

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 |
|---|---|---|
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| | | |
| | | |

**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:**