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ADULT LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In scientific work, records are necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program.

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. No outsider is permitted to see your case record without your written permission.

If you do not desire to answer any specific question, merely write, "Do not care to answer."

Name: _____

Street Address: _____

City, State, ZIP: _____

Home Telephone: _____

Cell Telephone: _____

Work Telephone: _____

Date of Birth: _____

Age: _____

Please sign and date on the last page.

Physical Health Issues

(a) Whom have you previously consulted about your present problem(s)?

_____

(b) Name(s) of physician(s) and telephone number(s). List all seen for the last 5 years.

Name: _____ Name: _____ Name: _____

Phone: _____ Phone: _____ Phone: _____

(c) List the last physician you saw, the date, and the reason:

Name: _____ Date: _____ Reason: _____

(d) Names of medications and dosage. List below, for what problem, and how they work.

Name	Dose	Reason	How Long	Effectiveness

Names other medications have you taken previously, for what problem, and how well they worked.

Name	Dose	Reason	How Long	Effectiveness

(e) Place of birth: _____

(f) Mother's condition during pregnancy with you (if known) _____

(g) Check any of the following that applied during your childhood:

____ Night terrors ____ Sleepwalking ____ Nail biting ____ Fears ____ Stammering

____ Unhappy childhood ____ Bedwetting ____ Thumbsucking ____ Others (list below):

Others: _____

(h) Health during childhood – list illnesses: _____

(i) Health during adolescence – list illnesses: _____

(j) Current Height: _____ Current Weight: _____

(k) Any surgeries? If yes, list below and age at the time:

Surgery: _____ Age: _____

Surgery: _____ Age: _____

(l) Allergies or sensitivities to medications or substances? If yes, list below:

_____

(m) Any accidents? If yes, explain: _____

_____

(n) Any history of witnessed or experienced trauma including abuse, neglect, violence or sexual assault? _____ Yes _____ No If yes, please explain:

_____

(o) Adjustment to any disorders? If yes, explain: _____

_____

(p) Nutrition – describe daily eating habits (i.e., when you eat, type of food):

_____

_____

(q) Put x next to any of the following that apply to you:

___ palpitations	___ bad conditions at home	___ conflict
___ excessive sweating	___ shy with people	___ overambitious
___ hypoglycemia (low blood sugar	___ feels tense	___ depressed
___ bowel disturbances	___ lonely	___ nightmares
___ fainting spells	___ take sedative	___ tremors
___ allergies	___ unable to have a good time	___ anxiety
___ can't keep a job	___ inferiority feelings	___ anger
___ can't make friends	___ financial problems	

(r) Are you currently pregnant: _____ Yes _____ No

If yes, are you receiving prenatal care? _____ Yes _____ No

Others: List additional problems or difficulties here: _____

_____

_____

_____

_____

_____

Name

Risk Factors for Suicide and Prevention

Individual Risk Factors	**Yes**	**No**
Mental health problems including depression, bipolar disorder, and anxiety disorders	Yes	No
Alcohol and other substance use problems	Yes	No
Loss (due to death, relationship, job, or status)	Yes	No
Poor impulse control	Yes	No
Feelings of hopelessness, powerlessness, or desperation	Yes	No
History of trauma or abuse (e.g. physical, mental, or sexual)	Yes	No
Prior suicide attempt	Yes	No
Fascination with death and violence	Yes	No
History of bullying or interpersonal violence	Yes	No
Confusion or conflict about sexual orientation/identity	Yes	No
Compulsive, extreme perfectionism	Yes	No

Family Risk Factors	**Yes**	**No**
Family History of suicide	Yes	No
Depressed and/or suicidal parents	Yes	No
Alcoholic and/or drug addicted parents	Yes	No
Changes in family structure (e.g. death, divorce, remarriage, frequent	Yes	No
Moves/relocation)	Yes	No
Financial Difficulties	Yes	No

Community Risk Factors	**Yes**	**No**
Access to lethal means (e.g. firearms or other lethal means)	Yes	No
Stigma associated with help-seeking	Yes	No
Lack of access to helping services	Yes	No
Loss of family, friends, or idols to suicide	Yes	No
Anniversary of someone else's suicide or other death	Yes	No
Incarceration or loss of freedom; trouble with the law	Yes	No

Mental and Emotional Status

(a) Underline any of the following words which apply to you:

accepted by others - affectionate - aggressive - apathetic - assertive - careless - confident - confused cooperative - demanding - dependent - determined - dependable - distrustful - fearful - forgetful - forgiving good-natured - hopeful - impulsive - independent - hopeless - intolerant - irresponsible - irritable intelligent - likeable - organized - outgoing - patient - rejected - worthwhile - resentful - self-centered - sensitive to others submissive - tolerant - trusting - unloved - withdrawn - worthless

Others you may wish to add: _____

_____

(b) List your 5 main fears: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

(c) Were you ever bullied or severely teased? Yes _____ No _____

(d) Do you make friends easily? Yes _____ No _____

(e) Do you keep them? Yes _____ No _____

Please indicate how each of the following symptoms or problems are affecting you. Please use this scale for each item and circle the appropriate number:

1 = not at all 2 = just a little 3 = about half the time 4 = much of the time 5 = all the time

	1	**2**	**3**	**4**	**5**
I enjoy being with friends	1	2	3	4	5
I can speak up for myself with others	1	2	3	4	5
I feel I can solve problems with others	1	2	3	4	5
I get a lot of support from my family	1	2	3	4	5
I am an important part of my family	1	2	3	4	5
I can say "no" to others when I need to	1	2	3	4	5
I avoid any conflicts with others	1	2	3	4	5
I need to be in control in most situations	1	2	3	4	5
I can become aggressive with others	1	2	3	4	5
I like the work that I do	1	2	3	4	5
I can manage my life about as well as anybody else	1	2	3	4	5

_____
Name

1= Not at all 2 = just a little 3= about half the time 4= much of the time 5= all the time

Cognitive-Emotional Indicators	**1**	**2**	**3**	**4**	**5**
Racing thoughts	1	2	3	4	5
Concentration problems	1	2	3	4	5
Memory problems	1	2	3	4	5
Restless	1	2	3	4	5
Can't make decisions	1	2	3	4	5
Suicidal thoughts	1	2	3	4	5
Fearful	1	2	3	4	5
Worrying	1	2	3	4	5
Panicky feelings	1	2	3	4	5
Crying easily or often	1	2	3	4	5
Feeling sad	1	2	3	4	5
Easily irritated	1	2	3	4	5
Loss of interest in other people	1	2	3	4	5
Fear of the worst happening	1	2	3	4	5
Unable to relax	1	2	3	4	5
Can't get things done	1	2	3	4	5
Loss of interest in my usual activities	1	2	3	4	5
Unable to have a good time	1	2	3	4	5

Physical-Somatic Indicators	**1**	**2**	**3**	**4**	**5**
Headaches	1	2	3	4	5
Allergies	1	2	3	4	5
Dizziness	1	2	3	4	5
Neck or back pain	1	2	3	4	5
Fatigue	1	2	3	4	5
Stomach problems	1	2	3	4	5
Sexual problems	1	2	3	4	5
Feeling faint	1	2	3	4	5
Sleep disturbance (unable to sleep, frequent waking, excessive sleeping)	1	2	3	4	5
Appetite problems (lack of appetite, excessive eating)	1	2	3	4	5
Substance abuse	1	2	3	4	5
Frequent use of aspirin or other painkillers	1	2	3	4	5

Current Lifestyle

(a) With whom and where to you live? _____

(b) Present interests, hobbies, and activities _____

(c) How is your free time occupied? _____

_____
Name

Occupational Data

(a) Describe current job _____

(b) Describe types of job held in the past _____

(c) Does your current work satisfy you? _____ If not, in what ways are you dissatisfied?

_____

(d) What do you earn? _____

(e) How much does it cost you to live? _____

(f) Career Ambitions – Past: _____ Present: _____

Education

(a) What was the last grade of school you completed? _____

(b) Scholastic Abilities – Strengths: _____ Weaknesses: _____

(c) Problems with reading and/or writing? If yes, explain_____

Sex Information

(a) Parental attitudes toward sex (i.e., was there sex instruction or discussion in the home?)

_____

(b) When and how did you arrive at your first knowledge of sex?

_____

(c) When did you first become aware of your own sexual impulses? _____

(d) Were you ever sexually molested as a child? _____

(e) Did you ever experience any anxiety or guilt feelings arising out of sex or masturbation? _____

If yes, explain _____

(f) Any relevant details regarding your first or subsequent sexual experience _____

_____

(g) Provide information about any significant heterosexual and/or homosexual reactions:

_____

_____
Name

(h) What is your sexual orientation? _____

(i) Is your present sex life satisfactory? If not, explain _____

(j) Are you sexually inhibited in any way? _____

Menstrual History

(a) Age at first period: _____

Were you informed or did it come as a shock? _____

Are you regular? _____ Duration _____ Do you have pain? _____

Date of last period _____ Do your periods affect your moods? _____

Marital History

(a) How long did you know your marriage partner before engagement? _____

(b) How long have you been married? _____

(c) Spouse's age _____

(d) Spouse's occupation _____

(e) Personality of spouse (in your own words) _____

(f) List areas of compatibility _____

(g) List areas of incompatibility _____

(h) How do you get along with your in-laws (including brothers- and sisters-in-law)? _____

_____

(i) How many children do you have? _____

(j) Do any of your children present special problems? _____

(k) Any relevant details regarding miscarriages or abortions? _____

(l) Comments about any previous marriage(s) and brief details _____

_____

(m) Give sex and age of children by your previous marriage _____

(n) Give sex and age of your partner's children by previous marriage _____

Family Data

(a) Father living or deceased? _____ If deceased, your age at time of his death _____

Cause of death _____ If alive, father's present age _____

His occupation _____ His health _____

(b) Mother living or deceased? _____ If deceased, your age at time of her death _____

Cause of death _____ If alive, mother's present age _____

Her occupation _____ Her health _____

(c) Siblings: Number of brothers _____ Ages _____

Number of sisters _____ Ages _____

(d) Give a description of your father's personality and his attitude toward you (past and present):

_____

(e) Give a description of your mother's personality and her attitude toward you (past and present):

_____

(f) In what ways were you punished as a child by your father? _____

In what ways were you punished as a child by your mother? _____

(g) Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and children.

_____

(h) Were you able to confide in one or both of your parents? _____

(i) Did one or both of your parents understand you? _____

(j) Basically, did you feel loved and respected by your parents? _____

(k) If you have a stepparent, give your age when parent remarried _____

(l) If you were not brought up by your parents, who did bring you up and between what years?

_____

_____
Name

(m) Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?

_____

(n) Who are the most important people in your life? _____

(o) Does any member of your family suffer from alcoholism or anything which can be considered a "mental disorder"? If so, explain: _____

_____

(p) Have you ever lost control (i.e., temper, crying, or aggression by hitting)? If so, describe:

_____

Religious Activity

Did/do you attend church and are you active?

(a) In childhood? _____ (b) As an adult? _____

Military History

(a) Have you ever been in a branch of the armed services? _____

If so, which one _____

(b) Dates of service and discharge _____

Legal Status

Have you ever been arrested? _____ If so, nature of circumstances and the disposition:

_____

Use of Substances

(a) Please indicate the type and amount of substances you use _____

(b) Please indicate any course of treatment undertaken for use of substances _____

_____

_____
Name

(b) Does any family member currently or in the past suffer from any type of substance abuse problem? If so, explain_____

In your own words, what are your personal strengths, needs, abilities, and/or interests and preferences?

_____

_____

_____

_____

Complimentary health approaches: What else have you tried before to help yourself reduce your problems/concerns?

_____

_____

Goals

(a) Please list three main changes you hope to make with the assistance of therapy:

(1) _____ (2) _____ (3) _____

(b) What is there about your present behavior that you would like to change?

_____

_____

(c) What feelings do you wish to alter (i.e., increase or decrease)?

_____

_____

Resources and involvement of client and others:_____

_____

_____

Name

Possible referrals to other community services:_____

Transition/Discharge Plan:

a. Criteria (client-specific behaviors):_____

_____

b. Estimated date of discharge (M/Y): _____

c. Aftercare plan: _____

_____
Client signature

_____
Date

_____
Therapist signature

_____
Date

_____
Name

5/19
cp