Insight Psychology, LLC

Life History Questionnaire - Adult

Today's Date: _____

Name: _____ Date of Birth: _____

Home Address: _____

Phone Number: _____ May we leave a voicemail? Y N

Phone Number (other): _____ May we leave a voicemail? Y N

Email Address: _____

What is your preferred mode of contact? Email Phone

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____ Phone Number (other): _____

PRESENTING CONCERNS

Please describe the problem(s) that bring you here:

_____

_____

_____

When did your problem(s) begin?

_____

_____

Please rate the severity of your problem(s) on the scale below:

Low 0 1 2 3 4 5 6 7 8 9 10 High

What are your current goals for treatment?

_____

_____

_____

GENERAL INFORMATION

Of what race do you consider yourself? _____

Do you have a religious preference? Yes No Religion: _____

MEDICAL HISTORY

Hospitalizations:

Date	Length of Stay	Reason for Hospitalization

Did you have any medical problems during childhood and/or adolescence? Yes No

If yes, please explain:

_____

_____

Do you have any current medical problems? Yes No

If yes, please explain:

_____

_____

Are you taking any prescribed medication for a physical problem? Yes No

If yes, please explain:

_____

_____

Circle any of the following words/terms that apply to you –

headaches	dizziness	fainting spells	heart palpitations
stomach trouble	feel anxious	bowel disturbances	fatigue
poor appetite	feel angry	use sedatives	insomnia
nightmares	feel panicky	increased alcohol use	feel tense
argue frequently	tremors	feel depressed	suicidal thoughts
use drugs	unable to relax	sexual problems	allergies
overly ambitious	uncomfortable w/people	difficulty making friends	feeling inferior
difficulty making decisions	difficulty keeping a job	memory problems	problems at home
financial problems	feel lonely	unable to have good time	often use painkiller
difficulty concentrating	excessive sweating	don't like weekends/vacations	

Other: _____

_____

_____

ALCOHOL & DRUG USE

How often have you used any of the following substances?

Substance	**Current Use:** *Number of days in the past month*	**Past Use:** *Approximate date of last use*
Alcohol		
Amphetamines		
Barbiturates		
Cocaine		
Hallucinogens		
Heroin		
Inhalants		
Marijuana		
Sedatives		
Tobacco		
Other:		

Have you ever been treated for alcohol problems? Yes No

Date	Length of Treatment	Length of Abstinence from Alcohol
_____	_____	_____
_____	_____	_____

Have you ever been treated for drug problems? Yes No

Date	Length of Treatment	Length of Abstinence from Drugs
_____	_____	_____
_____	_____	_____

EDUCATIONAL HISTORY

What is the highest level of education you completed? _____

Degree Earned: _____

Have you ever served in the military? Yes No

Branch of Service:_____ Type of Discharge: _____

EMPLOYMENT HISTORY

Current Occupation: _____

What has been your usual employment pattern in the past 5 years?

Full-time _____ Part-time _____ Retired _____ Student _____

Disability _____ Military Service _____ Unemployed _____

Other: _____

LEGAL HISTORY

Was this treatment prompted or suggested by the criminal justice system? Yes No

Have you ever been arrested? Yes No

If yes, please explain: _____

_____

Have you ever been incarcerated? Yes No

If yes, please explain: _____

_____

Are you currently involved in a legal case? Yes No

If yes, please explain: _____

_____

RELATIONSHIP HISTORY

Marital Status:

Never Married _____ Married _____ (How Long? ____) Separated _____ Widowed _____

Divorced _____ Living Together _____ (How Long? _____)

Committed Relationship/Living Apart ____ (How Long? _____)

Please rate your level of commitment to staying with your partner on the scale below:

Low 0 1 2 3 4 5 6 7 8 9 10 High

Family Members:

Name	Relationship	Age	Quality of Relationship	Living with you?

Have any of your relatives ever had a serious problem with alcohol and/or drugs? Yes No

If Yes-

Relative: Problem:

_____ _____

_____ _____

_____ _____

Have any of your relatives ever had a serious mental health problem? Yes No

If Yes-

Relative:	Problem:
_____	_____
_____	_____
_____	_____
_____	_____

With whom do you spend most of your free time?

Family _____ Friends _____ Alone _____ Other: _____

How many close friends to you have? _____

What do you like to do in your free time?

_____

_____

_____

Has anyone ever abused you emotionally? Yes No

If yes, please explain: _____

_____

Has anyone ever abused you physically? Yes No

If yes, please explain: _____

_____

Has anyone ever sexually abused you? Yes No

If yes, please explain: _____

_____

MENTAL HEALTH HISTORY

Previous mental health treatment:

Date	Length of Treatment	Reason for Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever experienced thoughts about wanting to die? Yes No

If yes, please explain:_____

_____

_____

Have you ever intentionally harmed yourself? (e.g., suicide attempts, cutting, etc.) Yes No

If yes, please explain: _____

_____

_____

Have you ever intentionally harmed someone else or had thoughts about it? Yes No

If yes, please explain: _____

_____

_____

Have you ever been hospitalized for psychological concerns? Yes N0

If yes, please explain: _____

_____

_____

Is there anything else you would like to share at this time? _____

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Clinician Date