



INTAKE ASSESSMENT

Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. 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 wish to answer a question(s), merely write "Do not care to answer," or leave it blank.

Client account #:

Form with fields: Today's Date, Your Name, Your Address, Your Phone Number, Your Age, Your Occupation, Social Security #, Date of Birth, Marital Status (Single, Engaged, Married, Remarried, Separated, Divorced, Widowed).

Form with fields: Who do you live with (list People Please) with Name and Relationship columns; Do you live in a house, hotel, room, apartment, etc.; State in your own words the nature of your main problems and their duration.

Form with field: On the scale provided, please estimate the severity of your problems: (please check one) with options: Mildly upsetting, Moderately severe, Very severe, Extremely severe, Totally incapacitating.

Form with field: Current home Environment: (check all that apply) with options: Caring, Supportive, Disciplined, Permissive, Strict, Undisciplined, Chaotic, Aggressive or violent.

Form with field: Whom have you previously consulted about your problem(s)?

Form with field: List the benefits you hope to derive from counseling?

Form with fields: Place of Birth; Mothers condition during pregnancy: (as far as you know)

Please describe discipline practices while growing up:	<hr/> <hr/>
Who was in your family unit during childhood: <i>(check all that apply)</i>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncles <input type="checkbox"/> Aunts <input type="checkbox"/> Other Males <input type="checkbox"/> Other Females:
What is your ethnic/cultural background:	<hr/> <hr/>
How has your ethnic/cultural background affected your life?	<hr/> <hr/>
Family drug/alcohol abuse:	Parent(s) Specify: _____ Siblings: _____ Others: _____
Please describe any history of mental illness in your family:	<hr/> <hr/>
Please describe any drug or alcohol abuse in your surrounding environment or neighborhood:	<hr/> <hr/> <hr/>
When were you last examined by a Doctor: <i>(please give name of Dr.)</i>	Date Last Examined _____ Name _____ Phone Number _____ Address _____ City _____ State _____ Zip _____
Do you have any current medical issues:	<hr/> <hr/>
Please list all medications you are currently taking: <i>(include all over-the-counter medications)</i>	<hr/> <hr/> <hr/>
Present interests, hobbies and activities:	<hr/> <hr/>
How is most of your free time occupied:	<hr/> <hr/>

<p>Please list your educational history:</p>	<p>_____</p> <p>Highest Grade Completed</p> <hr/> <p>High School Graduate?</p> <hr/> <p>Vocational or Additional Education</p> <hr/> <p>College Degree Conferred</p>
<p>Please list your work history:</p>	<p>_____</p> <p>Current Employer Address City State Zip</p> <hr/> <p>Former Employer Address City State Zip</p> <hr/> <p>Former Employer Address City State Zip</p>
<p>Please list your military service history:</p>	<p><input type="checkbox"/> Active <input type="checkbox"/> Reserve <input type="checkbox"/> Retired</p> <p>Dates: _____ Branch _____</p> <p>_____</p> <p>Type of Discharge</p>
<p>Please list your legal history:</p>	<p>Have you ever been arrested: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever been convicted of a crime: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>If yes, please specify</p> <p>Have you been on probation/Parole: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>If yes, Name of Parole/Probation Officer</p> <p>Is a Court hearing pending: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>If yes, Date/Location</p>
<p>What is your sexual orientation:</p>	<p>_____</p>
<p>Please list your sexual history:</p>	<p>_____</p> <p>_____</p>
<p>Please describe your marital history:</p>	<p>_____</p> <p>How long have you been married</p> <p>_____</p> <p>How long did you know your partner before engagement</p> <p>_____</p> <p>Spouse's Age Spouse's Occupation</p>
<p>Please describe in your own words your current spouse's personality:</p>	<p>_____</p> <p>_____</p>
<p>In what areas is there compatibility:</p>	<p>_____</p> <p>_____</p>
<p>In what areas is there incompatibility:</p>	<p>_____</p> <p>_____</p>
<p>How do you get along with your in-laws <i>(Include brothers & sisters in-law)</i></p>	<p>_____</p> <p>_____</p>

Give details of any previous marriage(s) of yourself and your spouse:	_____												
How many children do you have (Please list their sex and age(s):	<table border="1"> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> </table>	Name	Sex	Age	Name	Sex	Age	Name	Sex	Age	Name	Sex	Age
Name	Sex	Age											
Name	Sex	Age											
Name	Sex	Age											
Name	Sex	Age											
Describe the personality of each child (In your own words)	_____												
Is your Father living or deceased (If deceased, your age at time of his death)	<table border="1"> <tr> <td>Living or deceased</td> <td>Your age at time of death</td> </tr> <tr> <td>If alive, father's present age</td> <td>His occupation</td> </tr> </table>	Living or deceased	Your age at time of death	If alive, father's present age	His occupation								
Living or deceased	Your age at time of death												
If alive, father's present age	His occupation												
Is your Mother living or deceased (If deceased, your age at time of her death)	<table border="1"> <tr> <td>Living or deceased</td> <td>Your age at time of death</td> </tr> <tr> <td>If alive, Mother's present age</td> <td>Her occupation</td> </tr> </table>	Living or deceased	Your age at time of death	If alive, Mother's present age	Her occupation								
Living or deceased	Your age at time of death												
If alive, Mother's present age	Her occupation												
Siblings:	<table border="1"> <tr> <td>Number of Brothers</td> <td>Brother's ages</td> </tr> <tr> <td>Number of Sisters</td> <td>Sister's ages</td> </tr> </table>	Number of Brothers	Brother's ages	Number of Sisters	Sister's ages								
Number of Brothers	Brother's ages												
Number of Sisters	Sister's ages												

Do you have a history of physical abuse: (If yes, please specify)	_____
Do you have a history of sexual abuse: (If yes, please specify)	_____
Do you have a history of emotional abuse: (If yes, please specify)	_____
Do you have a history of psychological abuse: (If yes, please specify)	_____
Do you use alcohol: (If yes, please specify amount, frequency & duration)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Amount Frequency Duration
Do you use drugs: (If yes, please specify amount, frequency & duration & drug of choice)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Drug of choice Amount Frequency Duration
Use of Caffeine:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Amount
Use of Tobacco:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Packs per day

Do you regularly worship: <i>(If yes where)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ If yes where
What Religion:	
What Denomination:	
Do you pray:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you meditate:	<input type="checkbox"/> Yes <input type="checkbox"/> No
How Do you express your spirituality:	_____ _____
How important has spirituality experience been to you in the past:	_____ _____
What are your spirituality goals:	_____ _____
How has belief in God been important to you:	_____ _____
Does faith help you cope: How:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

<p>Please Add Any information not covered by this questionnaire that may aid your therapist in understanding and helping you.</p>
<p>_____ _____ _____ _____ _____ _____ _____ _____</p>