Life History Questionnaire – Adult

Please complete all information on this form and return to therapist before first session.
(All provided information is held in strict confidence). Email to Carolina.mirandalcsw@gmail.com

Full Name_____Date_____

Date of Birth _____ Age _____

Gender Identity: ____Male _____ Female _____ Transgender ____ Non-binary

Sexual orientation: ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

Ethnicity: ___Native/Indigenous/Alaskan Native ___ Asian ___Black/African American ___Hispanic/Latino (a)

____ Native Hawaiian/Pacific Islander ____Other Please Specify: _____

Relationship Status: ___ Single ___ Engaged ___ Married ____Divorced ___ Separated ____Other _____

Home Address: _____ City: _____ State: _____ Zip:_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? Current Therapist/Counselor_____ Therapist's Phone_____

Is this your first time in therapy? ( ) Yes ( ) No, When and Duration of treatment: _____

Briefly explain your need for counseling now: _____
_____
_____

What are your treatment goals?_____
_____
_____

Current Symptoms Checklist: (check all that apply and have been experienced for the past 2 weeks)

Feelings: ( ) Helpless ( ) Depressed ( ) Shameful ( )Angry ( )Guilty ( )Hopeless ( ) Lonely ( )Sad ( )Stressed

( )Anxious ( ) Out of Control ( )Afraid ( )Numb ( ) Mood Shifts ( )Overwhelmed ( ) Impulsivity

Thoughts: ( ) Confused ( ) Worthless ( )Unmotivated ( )Unattractive ( )Racing ( )Unlovable ( )Racing

( ) Distracted ( ) Obsessive ( )Paranoid ( )Suicidal ( ) Worried ( )Unorganized ( )Sensitive ( )Confident

Symptoms/Behaviors: ( ) Procrastination ( )Loss of interest ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance

( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Fatigue ( ) Crying spells ( ) Decreased libido ( ) Withdrawing Socially ( )Binge Drinking ( ) Acting out Aggressive ( ) Injuring Self

Suicide Risk Assessment-Have you ever had feelings or thoughts that you did not want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section. Do you currently feel that you do not want to live? ( ) Yes ( ) No

How often do you have these thought?

_____

When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Have you ever been hospitalized for mental health reasons? If Yes, please describe:
Hospital name: _____ Dates: _____Voluntary? _____
Reasons: _____ Outcome: _____
Are you currently taking any Rx medication for Mental Health diagnosis? If yes, please provide:
Name of Rx medication: _____ Dosage: _____ How long ago: _____
Name of Rx medication: _____ Dosage: _____ How long ago: _____
Name of Rx medication: _____ Dosage: _____ How long ago: _____

Past Medical History:
Please check all that apply:
( ) COVID-19 ( ) Thyroid Disease ( ) Anemia ( ) Liver Disease ( ) Chronic Fatigue ( ) Kidney Disease ( ) Diabetes
( ) Asthma/respiratory problems ( ) Stomach or intestinal problems ( ) Cancer (type) _____
( ) Fibromyalgia ( ) Heart Disease ( ) Epilepsy or seizures ( ) Chronic Pain ( ) High Cholesterol
( ) High blood pressure ( ) Head trauma ( ) Liver problems ( ) Pace Maker ( )Other _____

Primary Care Physician_____ Phone #: _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____
Family Medical History. Which Family Member? _____
_____
_____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
_____
_____

Family Psychiatric History: Has anyone in your family been diagnosed with any Mental Health Disorder?
If so what was the diagnosis? What family member? _____
_____

Substance Use: Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the greatest number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long?

_____

_____

Have you ever consumed any illegal substance, experimented, recreational purposes, excessive use? Please indicate what substance i.e., (Cocaine, Heroin, Methamphetamine, LSD).

_____

_____

Other substances that may be used, such as Marijuana, Tobacco, CBD. If so, please provide dosage and frequency.

_____

Family Background and Childhood History:

Mother's age _____ If deceased, your age when she died? _____
Father's age _____ If deceased, your age when he died? _____
Are your parents divorced? ( ) Yes ( ) No If yes, how old were you when it happened? _____
Number of Siblings _____
Name :_____ Age _____ Name :_____ Age _____

Name :_____ Age _____ Name :_____ Age _____

Name of Spouse/Significant other: _____ Years together: _____
Age: _____ Gender: _____ Occupation: _____ Education Level: _____

Do you have any children? ( )Yes ( )No How many? _____
Gender: _____ Age _____ Gender: _____ Age _____
Gender: _____ Age _____ Gender: _____ Age _____
Gender: _____ Age _____ Gender: _____ Age _____

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____

_____

If yes, have you ever received treatment for trauma(s)?

Educational History: Highest Grade Completed? _____ Did you attend college? _____
Where? _____Major? _____
What is your highest educational level or degree attained? _____
Occupational History: Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Legal History: Have you ever been arrested? _____ Do you have any pending legal problems? _____

Spiritual Life: Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Would you be interested in exploring a holistic approach to therapy such as Mindfulness, Sound Bath Healing, Energy Healing? ( ) Yes ( ) No

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____