



Licensed Clinical Psychologist, License # PSY18578 ♦ Marriage & Family Therapist, License # MFC16802

INTAKE ASSEMENT
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 #:

| | | | |
|--|------------------------------------|-----------------------------------|---|
| Today's Date: | | | |
| Your Name: | | | |
| Your Address: | | | |
| Your Phone Number: | | | |
| Your Age: | | | |
| Your Occupation: | | | |
| Social Security #: | | | |
| Date of Birth : | | | |
| Marital Status: <i>(Check one please)</i> | <input type="checkbox"/> Single | <input type="checkbox"/> Engaged | <input type="checkbox"/> Married <input type="checkbox"/> Remarried |
| | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |

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| Who do you live with: <i>(list People Please)</i> | Name _____ | Relationship _____ |
| | Name _____ | Relationship _____ |
| | Name _____ | Relationship _____ |
| | Name _____ | Relationship _____ |
| Do you live in a house, hotel, room, apartment, etc. | | |
| State in your own words the nature of your main problems and their duration. | _____ _____ | |

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| On the scale provided, please estimate the severity of your problems: <i>(please check one)</i> | <input type="checkbox"/> Mildly upsetting <input type="checkbox"/> Moderately severe <input type="checkbox"/> Very severe <input type="checkbox"/> Extremely severe <input type="checkbox"/> Totally incapacitating |
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| Current home Environment: <i>(check all that apply)</i> | <input type="checkbox"/> Caring <input type="checkbox"/> Supportive <input type="checkbox"/> Disciplined <input type="checkbox"/> Permissive <input type="checkbox"/> Strict <input type="checkbox"/> Undisciplined <input type="checkbox"/> Chaotic <input type="checkbox"/> Aggressive or violent |
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| Whom have you previously consulted about your problem(s)? | _____ _____ |
| List the benefits you hope to derive from counseling: | _____ _____ |

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| Place of Birth: | | | |
| Mothers condition during pregnancy: <i>(as far as you know)</i> | | | |

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| 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> | <hr/> Date Last Examined <hr/> Name Phone Number <hr/> Address <hr/> 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/> |

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| 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>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Name</td> <td>Sex</td> <td>Age</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</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>_____</td> <td>_____</td> </tr> <tr> <td>If alive, father's present age</td> <td>His occupation</td> </tr> <tr> <td>_____</td> <td>_____</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>_____</td> <td>_____</td> </tr> <tr> <td>If alive, Mother's present age</td> <td>Her occupation</td> </tr> <tr> <td>_____</td> <td>_____</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>_____</td> <td>_____</td> </tr> <tr> <td>Number of Sisters</td> <td>Sister's ages</td> </tr> <tr> <td>_____</td> <td>_____</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 | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | |

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| 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 |

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| 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 _____ |

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