

Life History Questionnaire

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The purpose of this questionnaire is to obtain some information regarding the issues that bring you in today, as well as some of your experiences and background. Completing these questions as fully and as accurately as possible will benefit you through the development of a treatment plan suited to your specific needs.

Name: _____ Date: _____

Address: _____

Home Phone: () _____ Cell Phone:() _____

DOB: / / Age: Occupation: _____

By who were you referred? _____

SIGNIFICANT RELATIONSHIP STATUS:

Single Engaged Married Separated Divorced Widowed Committed Relationship

LIST ANY MEDICATIONS YOU ARE TAKING:

<u>Name</u>	<u>Dosage</u>	<u>Prescribed for</u>
_____	_____	_____
_____	_____	_____

PLEASE STATE WHAT BRINGS YOU IN:

How long has this been occurring? _____

On the scale below, please circle the severity:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**
 mildly upsetting ← — — — — — — — → incapacitating

ALCOHOL AND OTHER DRUG USE

Please tell me about your use of alcohol and other substances:

	Never	Seldom	Once a month	2-3 times a month	Weekly	Daily
I drink 4 or more drinks in a 24-hr period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to drinking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After drinking, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I use other recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After using recreational drugs*, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**RECREATIONAL DRUGS INCLUDE, among others: marijuana; cocaine; ecstasy; heroin; meth; as well as any prescription or over-the-counter drugs taken for recreational purposes.*

PREVIOUS MENTAL HEALTH TREATMENT:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen.

FAMILY MENTAL HEALTH HISTORY

Clinical Diagnosis	NO ONE	If YES, please check the box for <u>all</u> applicable family members							Successfully Treated?	
		Mother	Father	Brothers	Sisters	Cousins	Aunts/Uncles	Grand-parents	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD (Attention Deficit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borderline Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Other Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family mental health information: _____

HOME/FAMILY EXPERIENCES

Did the following occur in your family/home environment?	Yes	No	Not Sure
Parents divorced or permanently separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent, hostile arguing among family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a parent or sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) or sibling(s) with a drinking or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with an eating problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with a debilitating illness, injury, or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member prosecuted for criminal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member attempted/committed suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			WORK/ACADEMIC CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Procrastination
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Time management
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Poor performance evaluations/grades
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Test, speech, or performance anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Fearfulness/paranoia	<input type="checkbox"/>	<input type="checkbox"/>	Conflict with a colleague, boss, or professor/teacher
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	BODY IMAGE AND FOOD USE		
<input type="checkbox"/>	<input type="checkbox"/>	Compulsions/rituals	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Purging (vomiting)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Motivation problems	<input type="checkbox"/>	<input type="checkbox"/>	Diet pill use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>falling</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Restricting food intake or avoiding food/fasting
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>staying</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Overeating
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dieting
<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	Being overweight or underweight
<input type="checkbox"/>	<input type="checkbox"/>	Irritability/anger/hostility	<input type="checkbox"/>	<input type="checkbox"/>	Excessive exercise
<input type="checkbox"/>	<input type="checkbox"/>	Mania (overly energized with unusual thoughts or behaviors)	ADDICTION/DEPENDENCE CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings/thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt(s)	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction/dependence/overuse/abuse
ROMANTIC RELATIONSHIP CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Prescription drug addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Dating concerns	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sex	<input type="checkbox"/>	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	Excessive internet use
<input type="checkbox"/>	<input type="checkbox"/>	Break-up/end of romantic relationship	<input type="checkbox"/>	<input type="checkbox"/>	Sexual addiction
SOCIAL RELATIONSHIP CONCERNS			CONCERNS INVOLVING VIOLENCE		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making friends	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted sex
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Being stalked
<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Intimate relationship violence
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	Problems with anger control
GENDER/SEXUAL ORIENTATION CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Participant in a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Gender identity or gender issues	<input type="checkbox"/>	<input type="checkbox"/>	Witness of a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Lesbian/gay/bisexual issues or orientation questions	<input type="checkbox"/>	<input type="checkbox"/>	Perpetrator of abuse (physical/sexual/psychological)
<input type="checkbox"/>	<input type="checkbox"/>	Transgender issues	<input type="checkbox"/>	<input type="checkbox"/>	Survivor of abuse (physical/sexual/psychological)