Life History Questionnaire
(All files are held in strict confidence)

Date _____

First Name _____ MI _____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender: ☐ Male ☐ Female

Relationship Status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Working status ☐ Full time ☐ Part time ☐ Retired

Address	City	State	Postal Code

Personal Phone	Cell Phone	May we leave a message?	Best times to call?
		☐ Yes ☐ No	

Email Address:

Full time occupation:

Will you be able to make and keep regularly scheduled appointments?

Please indicate how you found out about Holistic Brain Health!

Referral Type ☐ Brochure/ biz card ☐ person ☐ web

Referral link / web source? _____

Person I should thank: _____

Please read the following questions and mark those to which you would respond "yes."

☐	Have you previously been involved in counseling?	☐	Have you ever been hospitalized for mental health reasons?
☐	Do you currently use alcohol or other non-prescription drugs?	☐	Is there a history of alcohol or drug problems in your family?
☐	Is there a history of mental health problems in your family?	☐	Have you ever been in legal trouble?
☐	Have you ever been physically abused?	☐	Have you ever been sexually abused or assaulted?
☐	Have you ever been emotionally abused?	☐	Are your concerns interfering with your ability to stay in your job?
☐	Are your concerns interfering with your work?	☐	Have you ever attempted suicide?

Please describe the concerns that you would like to discuss:

How long has this problem persisted?	Under what condition do your problems get worse? better?

What methods have you tried before? How long did you try them? Did they work for you? Why or why not?

Please use the following scale to answer the next three questions:	1	2	3	4
	Not at all	Mildly	Moderately	Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

What do you think your greatest blocks are to resolving your present concerns?

What would your ideal life look like? Try to express this using language of what you want (not what you want to clear).

What do you hope to achieve with our work together?

Do you believe you can reach your dreams? Why or why not?

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:

Life History Questionnaire pg 3

Family History	
	Mother's Age _____ If deceased, how old were you when she died? _____
	Father's Age _____ If deceased, how old were you when he died? _____
	If your parents are separated, how old were you then? _____
	Number of brother(s) _____ What are their ages? _____ _____ _____ _____
	Number of sister(s) _____ What are their ages? _____ _____ _____ _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:	Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

Briefly describe your past and current relationships with your:

Mother	Father
Stepmother	Stepfather
Spouse	
Offspring	

Life History Questionnaire pg 4

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Lightheadedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you: