CONFIDENTIAL

"Life History" Questionnaire

Please fill out whatever is applicable to you.
If you need more space for any answer, please use the back of the sheet.

General Information

Today's Date: _____

Name: _____ Male / Female

Address: _____

City: _____State:_____ Zip: _____

Date of Birth:_____ Referred by:_____

Phone: (home)_____ Work:_____

Cell:_____ (E-mail)_____

Marital Status (circle one)

Single / Engaged Cohabitating Married Separated Divorced Widowed

Are you a student? Yes___ No___ Where? _____

Studying what? _____

Employed? Yes____ No____ Full Time/Part time _____

Employment Date _____

Employer _____

Address _____

Occupation _____

Presenting Problem

What do you hope to accomplish in counseling?

On the scale below, please estimate the severity of your problems:

Mildly	Moderately	Very	Extremely	Totally
Upsetting___	Upsetting____	Upsetting____	Upsetting___	Upsetting__

When did your problems begin? Please give dates.

Please describe significant events occurring at the time, or since then, which may relate to the development or maintenance of your problems.

So far, what solutions to your problems have been most helpful?

Have you been in counseling before or received any professional assistance for these or other problems? If so, please give names, professional titles, dates of treatment and results.

Have you ever been hospitalized for psychological problems? Yes___ No___ If yes, when and where?

PERSONAL AND SOCIAL HISTORY

Siblings: Please list all of your siblings by sex, name, age and if they are still living. For those deceased, please give date and cause of death.

Male / Female	Name	Age	Living / Deceased	If deceased, date of death & cause

If your father is living, what is his age? ___ His occupation? _____

State of his health? _____

If your father is deceased, what was his age at the time of death?_____

How old were you at the time? ___ Cause of death?_____

If your mother is living, what is her age? __ Her occupation?_____

If your mother is deceased, what was her age at the time of death?_____

How old were you at the time?___ Cause of death?_____

If applicable, please provide the following information

Name of your Partner (current)_____

Partner's Age__ ___ Partner's Occupation_____

When married?_____

How long did you know one another before your engagement? _____

Marital Status: Still married___ Separated____ Divorced ___ Deceased___

When?_____

CHILDREN:

Please list children and step children by sex, name, and age.

Male / Female	Name	Age	Living / Deceased	If deceased, date of death & cause

FRIENDS

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? Yes___ No___

Do you have a family physician? If YES, please provide the following:

Physician's Name _____

Address _____

Phone Number _____

Do you own a gun? Yes___ No___

RELIGION

As a child? _____

As an adult? _____

EDUCATION

Last grade completed? _____ Degree?_____

How would you describe your academic performance:

Excellent___ Above Average____ Average____ Low Average____ Poor___

What were scholastic strengths and weakness?

Did you date much in high school? Yes___ No___

Did you date much in college? Yes___ No___

Circle any of the following that applied during your childhood/adolescence:

Happy Childhood	School Problems	Medical Problems
Unhappy childhood	Family Problems	Alcohol Abuse
Emotional / Behavior Problems	Strong Religious Convictions	Drug Abuse
Legal Problems	Other	

Does any member of your family suffer from, Alcoholism, Epilepsy, Depression, Mental Disorders? If yes, please describe:

Are you currently (or have ever been) in an abusive relationship? Yes__ No_

Have you ever attempted suicide? Yes__ No__

Has any relative attempted or committed suicide? Yes__ No___

Has any relative had serious problems with the law? Yes__ No__

PHYSICAL SENASTIONS
CIRCLE any of the following that often apply to you:

Headaches	Dizziness	Dry Mouth
Palpitations	Stomach trouble	Burning or itchy
Muscle Spasms	Skin Problems	skin Chest pains
Tension	Tics	Rapid heart beat
Sexual disturbance	Fatigue	Blackouts
Bowel	Twitches	Excessive sweating
disturbances	Back pain	Visual Disturbance
Tingling	Fainting spells	Hearing problems
Numbness	Hearing things	Flushes
	Watery eyes	

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Yes__ No__
If YES describe:

Are you currently taking medications or supplements? Yes___ No___
If yes, please list any medications or supplements you are currently taking, or have taken during the past six months **include aspirin, birth control, prescription or over the counter medicines.**

Have you had accidents or injuries not previously describe? Yes__ No__
If yes, please provide details and dates:

Have you ever had any head injuries or loss of consciousness? Yes__ No__
If yes, please give details and dates:

Have you had surgery? Yes__ No__
If yes, please give details and dates:

Female Clients please complete this section.

Do your periods affect your mood? Yes ___ No___

Any relevant information about abortions or miscarriages? If yes, please describe:

_____

CHECK ANY THAT APPLY TO YOU WITHIN THE PAST YEAR

	NEVER	SOMETIMES	VERY OFTEN
Marijuana			
Tranquilizers			
Sedatives			
Aspirin			
Cocaine			
Painkillers			
Alcohol			
Coffee			
Cigarettes			
Narcotics			
Stimulants			
Hallucinogens, LSD			
Diarrhea			
Constipation			
Allergies			
High Blood Pressure			
Heart Problems			
Nausea			

Vomiting			
Insomnia			
Headaches/Backaches			
Eat “Junk Foods”			
Early Morning Awakening			
Fitful Sleep			
Overeat			
Poor Appetite			

Consent to Treatment

I do hereby seek and consent to take part in the treatment or evaluation of myself or my child and I agree to play an active role in this process.

Your Rights

I am aware that I may stop my treatment with my therapist at any time.
The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I also have the right to ask questions about my therapist's clinical background and qualifications or questions about any procedures or methods used in treatment.

Limitation on Confidentiality When Treating Couples

There are slightly different expectations and limits about confidentiality in couple therapy than there are in individual therapy. In couple therapy the couple is the client. For instance, if there is a request for the treatment records of the couple, I will need the authorization of both members before I release confidential information. Also, if my records are subpoenaed, I will assert the therapist-patient privilege on behalf of the couple, not just an individual.

During the course of therapy with a couple I may see either individual alone for one or more sessions. These sessions are a part of the couple therapy. These sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. However, I may need to share information learned in an individual session with both members of the couple, if I am to effectively serve the couple being treated. I will use my best judgment as to whether, when, and to what extent I will make such disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to

be shared with no one, you might want to consult with a different therapist who can treat you separately.

This "no secrets" policy is intended to allow me to treat the couple more effectively by preventing, to the extent possible, a conflict of interest that might arise if an individual's interests are not consistent with the interests of the couple being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple during their therapy, I might be placed in a situation where I will have to terminate treatment. This policy is intended to prevent the need for such a termination.

I acknowledge by my signature below that I have read this policy, that I understand it, that I have had an opportunity to discuss its contents with our therapist, and that I enter therapy in agreement with this policy.

FINANCIAL POLICY

Please take a few minutes to read this to avoid misunderstandings about payment. **Current rate is $195 per 45 minute session and is always expected and required at the time of your visit.** You may pay cash, check or Visa, MasterCard or American Express. If you would like to automatically use your credit card as payment each time you come, you will need to complete the portion of this form below.
Checks returned by your bank are subject to a **$ 25.00 processing** charge. Accounts unpaid after **30 days** from the date of billing may be subject to a finance charge at the rate of **0.5% per month (6% per annum).** Accounts with an outstanding balance of **90 days are automatically referred for collection.** If your account must be referred to an outside agency for collection, you will be responsible for collection costs up to **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

If you are not able to keep a scheduled appointment and do not give at least 24 hours notice or fail to show up for your scheduled appointment, you are subject to being charged for the missed appointment. If you are a member of a group, **you will be billed for every session the group convenes whether you attend or not.**

We would like to take this opportunity to welcome you and assure you that we will do our utmost to provide you with the best care possible.

I have read and understand the Financial and Consent to Treatment Policy.

Client Name: _____
Please Print

_____ Date Signed: _____
Signature of Client or Responsible Individual

**********OPTIONAL**********

CREDIT CARD AUTHORIZATION

I authorize you to bill my credit card at the time of my visit.

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____ Zip Code:_____

3 digit security code on back of card: _____

Signature: _____ Date: _____