GROWING EDGES, LLC
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Life History Questionnaire

Date: _____

The purpose of this questionnaire is to obtain information about you, so that I can better meet your request for treatment. Completing this document as thoroughly and accurately as possible will facilitate our work together.

Because this information is highly personal, it is understandable that you may have concerns about how this document is treated. As explained in the Informed Consent form supplied, this and all material in your file is strictly confidential.

If you prefer not to answer a particular question or if it is not applicable, please just mark it "N/A."

1) General Information:

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Apt. Number: _____ City: _____ State: _____ Zip Code: _____

Email Address(es): _____; _____

Social Security Number (only if you plan to bill insurance): _____

Phone: hm: _____ wk: _____ cell: _____

Occupation & Employment Situation: _____

Education: _____

Have you ever been in the Military? ○ Yes ○ No Status

Relationship Status (please choose one):

○ Single ○ Married ○ Partnership ○ Separated ○ Divorced ○ Remarried ○ Widowed

If you have a partner: How long have you been together? _____

How long have you been living together? _____ Age of partner: _____

Education and occupation of partner: _____

Do you have any children? ○ Yes ○ No

If yes, how many live with you? _____ Please list their names, ages and genders:

_____

_____

Please note any other important information (step, adopted, etc.):

_____

_____

Present Family Concerns: _____

_____

Present Family Strengths: _____

_____

Any Significant Marital/Sexual Patterns? _____

2) Medical History:

Family physician: _____ phone number: _____

Psychiatrist: _____ phone number: _____

May I have permission to contact either or both doctors and acknowledge that you are attending therapy? ○ Yes ○ No (If yes, I will provide a Release of Information Form for you to sign)

Do you currently have any medical problems that require treatment? ○ Yes ○ No

If yes, please describe problem and nature of treatment: _____

_____

_____

Are you currently taking any medications? ○ Yes ○ No

If yes, please list (kindly include prescription and non-prescription)

Current Medications				
Name	Dosage	When Started	Reason	Prescribing Doctor

Please list any other significant medical problems, accidents and head injuries that you have had:

_____

_____

_____

Have you had or do you currently have any suicidal thoughts or actions?* (Circumstances? When? How treated?)_____

_____

_____

**If you have reported that you do have or have had suicidal ideation or actions, please fill out the Columbia-Suicide Severity Rating Scale attached to the intake forms email.*

Substance use/addictions:

Do you use any recreational drugs? ○ Yes ○ No

If yes, please list and describe approximate frequency and quantity:

_____

Approximately how much alcholol do you consume weekly? _____

Have you ever been criticized for your drinking or drug use? _____

Have you ever felt guilty for your drinking or drug use? _____

Have you ever tried to cut down on your use of alcohol or drugs? _____

How do drinking and drugs use generally affect you? _____

_____

Gambling issues? _____

Do you use tobacco products? ○Yes ○No Which? _____

When did you begin? _____

How much and how often? _____

4) Comfort and Social Network:

Do you have someone with whom you can share personal problems or go to for comfort?

○ Yes ○ No If yes, who is it? _____

_____

Do you ever turn to food, alcohol, drugs, sex, pornography, gambling, shopping, or other behaviors for comfort? If yes, please circle the item(s) above and/or describe others: _____

_____

_____

How do you spend your leisure time? _____

_____

Do you belong to any clubs or organizations (church group, PTA, etc.)? _____

_____

5) Family of Origin History (kindly list below any information about your father, mother, step-parents, siblings, etc. that you feel is significant):

Name Relationship Age (or at time of death) Occupation Education Other

_____

_____

_____

_____

_____

_____

_____

_____

If you were to choose 3 adjectives or phrases to describe your mother as you were growing up, what would they be?

_____; _____; _____

What sort of relationship did you have with your mother? _____

_____

If you were to choose 3 adjectives or phrases to describe your father as you were growing up, what would they be?

_____; _____; _____

What sort of relationship did you have with your father? _____

_____

Were your parents openly affectionate? _____ Did they fight? _____

Did they resolve arguments and get close again? _____

Whom did you approach for comfort? _____

Problems in Family of Origin? _____

_____

What was the mood of the house? _____

Please comment on any other significant relationships that were influential on you while growing up:

_____

_____

_____

_____

6) Romantic Relationship History (please list below your **<u>significant</u>** past relationships):

Partner's name	Your age when relationship began	Partner's age	Your age when relationship ended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were you able to find comfort in your previous relationships? _____

_____

7) Current relationship (please skip this section if you are not in a relationship):

Level of commitment to relationship:

○1 ○2 ○3 ○4 ○5

low (choose number) high

Level of distress in relationship:

○1 ○2 ○3 ○4 ○5

low (choose number) high

What are the things you like most about your relationship? _____

_____

_____

_____

_____

What are the things you most want to change? _____

_____

_____

_____

_____

How often do you argue? _____

What do you argue about the most often? _____

_____

_____

Describe your most recent argument. How did it start? How did it end? _____

_____

_____

_____

_____

When you argue, does someone end up leaving? Who? How long before they come back?

_____

_____

How long do you stay angry with each other? _____

_____

Who is the first to attempt to make things better? _____

_____

Have your arguments ever become physical? _____

_____

Who initiates sex most often? _____

_____

8) Cultural/Religious Information:

What is your race/ethnicity? _____

How much do you identify with your ethnicity? _____

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
Not at all (choose number) Strongly

Religious or spiritual preference: _____

Are you currently active in your religious/spiritual practice? _____

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
Not at all (choose number) Strongly

Are there any specifics aspects about your ethnic or religious values or experience that you feel it might be helpful for me to know?

_____

_____

Any ethnic related concern? _____

9) Other information:

Do you have difficulty sleeping? ○ Yes ○ No

Have you experienced physical, sexual or emotional abuse? ○ Yes ○ No ○ Not certain

If yes or not sure, please describe: _____

_____

_____

Is there any other information you think may be helpful for me to know? _____

_____

_____

10) Expectations for Therapy:

What prompted you to seek therapy at this particular time? _____

_____

_____

What symptoms are you experiencing? _____

_____

When did the issues that brought you into therapy begin? What makes them worse? Better?

_____

_____

If therapy is successful, how will you and your life be different? _____

_____

What are your goals for therapy? _____

_____

Have you been in therapy before? ○ Yes ○ No If Yes, please explain: when/therapist/helpful?

_____

_____

Do you have particular treatment preferences? _____

Personal strengths and abilities _____

_____