

Lorrie Brubacher, M Ed.

Licensed Marriage and Family Therapist RMFT # 89116, Canadian Counsellor Certification (# 125)

Date: _____

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain some information about you so that I can better meet your request for service. Completing this questionnaire as fully and as accurately as you can will facilitate the development of your therapy experience.

It is understandable that you may be concerned about what happens to this information about you, because this information is highly personal. As explained in the information form that you read, all material in your file is strictly confidential.

If you prefer not to answer any question, just write: N/A (No answer). If you need extra space, use reverse side.

1. General Information (please print)

Name: _____

Address: _____

postal code: _____

Telephone: (home) _____ (office) _____ (cel) _____

Permission to leave message? home: Yes/No office: Yes/No cell: Yes/No

Age: _____ Date of Birth: _____

Education: _____

Occupation and employment situation: _____

Relationship Status: (circle one; the following items apply to both heterosexual and homosexual relationships):

Single, Married, Common-Law, 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 children? Yes No

If yes, how many live with you? _____

Please list your children's names, age and gender: _____

2. Medical History

Name of family physician: _____

Telephone number: _____

May I have permission to contact your medical doctor and acknowledge that you are attending therapy?
Yes No

Do you currently have any medical problems that require treatment? Yes No
If YES, please describe the problem and nature of the treatment:

Are you taking any medication at this time? Yes No
If YES, please list (include both prescription & non-prescription medication):

What other serious medical problems or accidents have you had?

Do you have any special physical needs? (please describe)

3. Chemical Use:

Do you use recreational drugs? Yes No

If YES, please list: _____

How frequently do you use alcohol? _____

How much beer, wine or hard liquor do you consume each week? _____

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

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

How do drugs and/or alcohol effect you? _____

4. Comfort: Do you/did you ever turn to alcohol, drugs, sex, pornography, gambling, food, shopping or other material things _____(describe) for comfort? (Circle relevant items.)

5. 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? _____

How do you spend your leisure time?

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

6. Family History

Relative:	Name	Current age (or age at death)	Illness (or cause of death)	Education	Occupation
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Father: _____

Mother: _____

Others(step parents/grandparents):

Siblings: _____

(Use reverse side if necessary)

Are there any specific aspects about your ethnic or religious values and/or experience that you feel would be helpful for me to know? If so, please describe:

9. Other Information

Do you have difficulty sleeping? Yes No

Have you experienced abuse? None: Not Sure:

Physical abuse Emotional abuse Sexual abuse
(Please circle what you have experienced)

Is there any other information you think may help the therapist understand you?

10. Expectations for Therapy

What prompted you to seek therapy at this time?

What changes would you like to make?

11. Referral: How did you find out about me? _____

If someone suggested that you call this office, please provide name and contact information (optional):

Name: _____ Phone: _____

Address: _____

May I have permission to contact this person and acknowledge the referral? Yes No

Thank you for taking time to complete this form.
