

**Lorrie Brubacher, M Ed.**

Licensed Marriage and Family Therapist LMFT # 1245 (NC)

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? \_\_\_\_\_

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

How do drugs and/or alcohol effect you? \_\_\_\_\_

**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/did you ever turn to alcohol, drugs, sex, pornography, gambling, food, shopping or other material things \_\_\_\_\_ (describe) for comfort? (Circle relevant items.)

How do you spend your leisure time?

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

**5. 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:

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**8. 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?

**9. Expectations for Therapy**

What prompted you to seek therapy at this time?

What changes would you like to make?

**10. 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.

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