Life History (Intake) Form

Therapist name: Lorrie L. Brubacher, M. Ed.

License: 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, you are free to leave it blank.

1. General Information (please print)

Name: _____

Address: _____
postal /zip code: _____

Preferred Telephone Contact _____
Permission to leave message? Yes ◯ No ◯

Age: _____Date of Birth: _____

Education: _____
Occupation and employment situation: _____
_____

Relationship Status:

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. <u>Medical History</u>

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 ◯
yes, who is it? _____
Do you/did you ever turn to alcohol, drugs, sex, pornography, gambling, food, shopping or other material things for comfort? List 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
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____

Others(step parents/grandparents)
_____
_____
Siblings: _____
_____
_____
_____

If you were to choose three adjective 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 three adjective 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? _____

Who did you go to for comfort as a child?_____

Comment on any significant relationships that have been influential in your experience growing up.
_____

6. <u>Relationship History:</u>

Partner's name	Partner's age when relationship began	Your age when relationship began	Your age when relationship ended
1.: _____	_____	_____	_____
2.: _____	_____	_____	_____
3.: _____	_____	_____	_____

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

<u>Current Relationship:</u>

Level of commitment to relationship:
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯
Low High

Level of distress in relationship:
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯
Low High

7. <u>Cultural/Religious Information:</u>

1. What is your race/ethnicity? _____

2. How much do you identify with your ethnic heritage?

1 ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯
Not at all Strongly

3. Religious or spiritual preference _____

4. Are you currently active in your religion/spiritual practice?

1 ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯
Not at all Somewhat Yes

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:

_____

8. Sexuality: What is your sexual orientation? heterosexual ◯ gay/lesbian ◯ bisexual ◯ other ◯ unsure ◯

Sexual Relationship From 1(low) to 5 (high)

How satisfied are you with your sexual relationship? _____

How satisfied do you perceive your partner to be regarding your sexual relationship? _____

9. **Other Information**

Do you have difficulty sleeping? Yes ◯ No ◯

Have you experienced abuse? None: ◯ Not Sure: ◯

Physical abuse ☐ Emotional abuse ☐ Sexual abuse ☐

(Please check 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 contact 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.