mind·body·spirit

CENTRAL PSYCHOLOGICAL SERVICES, LLC

6335 S. East Street
Indianapolis, IN 46227

Life History Questionnaire
(All files are held in strict confidence)

Client Information Date _____

First Name _____ MI _____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender:__

Ethnicity
☐ Asian/Pacific Islander ☐ Hispanic
☐ American Indian ☐ White
☐ Black ☐ Other

Relationship Status
☐ Single ☐ Engaged
☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Relationships

Spouse/Partner's name_____ Years married/time together_____

Number of Children_____ Names & Ages_____

If Divorced, Length of Marriage(s)_____ Reason for Divorce(s)_____

_____

Please indicate who referred you to the CPS, LLC

Referral Type ☐ Self ☐ Clergy ☐ Brochure/Flier ☐ Doctor
☐ Friend ☐ Family ☐ Website ☐ Other

Referral Name (optional)

Please read the following questions and mark those to which you would respond "yes."

☐ Have you previously been involved in counseling?
☐ Do you currently use alcohol or other non-prescription drugs?
☐ Is there a history of mental health problems in your family?
☐ Have you ever been physically abused?
☐ Have you ever been emotionally abused?
☐ Are your concerns interfering with your work/academic performance?
☐ Have you ever attempted suicide?
☐ Have you ever been hospitalized for mental health reasons?
☐ Is there a history of alcohol or drug problems in your family?
☐ Have you ever been in legal trouble/arrested?
☐ Have you ever been sexually abused or assaulted?
☐ Are you currently taking any prescription medications?
☐ Are your concerns interfering with your ability to stay in school?

Please describe the concerns that you would like to discuss with a counselor:

How long has this problem(s) persisted?

Under what condition do your problems get worse? better?

What have you done to address your concerns?

Consequences of the aforementioned concerns:

Please use the following scale to answer the next three questions:

	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History

Mother's Age _____ If deceased, how old were you when she died? _____

Father's Age _____ If deceased, how old were you when he died? _____

If your parents are separated/divorced, how old were you then? _____

Number of brother(s) _____ What are their ages? _____ _____ _____ _____

Number of sister(s) _____ What are their ages? _____ _____ _____ _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:

Briefly describe your father's personality:

Briefly describe your childhood:

Briefly describe your past and current relationships with your:

Spouse/Partner/Boyfriend/Girlfriend

Sibling(s)

Mother

Father

Religious Affiliation

☐ Catholic ☐ None, but I believe in God

☐ Jewish ☐ Atheist or agnostic

☐ Protestant _____ ☐ Other _____

Do you desire to have your religious beliefs and values incorporated into the counseling process?

☐ Yes ☐ No ☐ Not Sure

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Indifferent/Apathetic
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Fantasy/Daydreaming
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Unusual/Bizarre
- ☐ Guilt

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Suicidal Thoughts/Attempts
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Missing Work/Classes
- ☐ Difficulty with Decision Making
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career Problems
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Self-Critical
- ☐ Sexual Problems
- ☐ Keyed Up/Excessive Energy
- ☐ Marital Conflict
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Nightmares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Financial Difficulties
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired/Fatigued
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Goals for counseling and/ or anything else you would like us to know about you: