ADULT LIFE HISTORY QUESTIONNAIRE

The purpose of the questionnaire is to gather a thorough understanding of your life experience and background. Please respond as completely as you can and are willing to as this will benefit the development of your plan for treatment.

General and Demographic Information

Name of Client: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone #: _____Is this your (circle): Cell Home Work
Can we: Call? __Y __N Leave a voicemail? __Y __N Text? __Y __N
Can we e-mail? __Y __N E-mail address: _____
Preferred method of contact (circle): Call Text E-mail

How did you find Silver Linings Counseling? _____

How long have you lived at your current address? _____
Of what race do you consider yourself? _____
What is your religious preference, if any? _____

Emergency Contact/Relationship to Client: _____
Primary phone: _____ Alternate phone: _____

Primary Insurance Provider: _____
Name of Subscriber/Relationship to Client: _____
Subscriber's Employer: _____
Subscriber's Birthdate: _____ Subscriber's Phone #: _____

Secondary Insurance Provider: _____
Name of Subscriber/Relationship to Client: _____
Subscriber's Employer: _____
Subscriber's Birthdate: _____ Subscriber's Phone #: _____

What brings you in today? _____
_____
_____

When did your problem begin? _____
What are your goals for treatment? _____
_____

Please rate your progress on your goals on the scale below:
(Not achieved at all) 0 1 2 3 4 5 6 7 8 9 10 (Totally achieved)

Medical History

What is your height? _____ feet _____ inches What is your weight? _____ pounds
How much exercise do you get a week? _____ hours Type: _____

How many times have you been hospitalized for a medical reason in your lifetime? _____

Date	Reason for Hospitalization	Length of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medical problems are you currently experiencing, if any? _____
_____
What medical problems have you had in the past, if any? _____
_____
What medications are you currently prescribed, if any? _____
_____
Do you find these medications to be helpful in treating your symptoms? ____Yes ____ No
If not, please explain: _____

Please circle any problems that apply to you:

headaches	dizziness	fainting spells	heart palpitations
stomach trouble	anxiety	bowel disturbances	fatigue
poor appetite	anger	panic	insomnia
nightmares	drug use	alcohol use	tension
depression	suicidal thoughts	frequent arguing	difficulty relaxing
social difficulties	job difficulties	financial difficulties	excessive sweating
memory problems	chronic pain	loneliness	tremors
allergies	family problems	too much energy	intrusive thoughts/images
difficulty focusing	social fears	inferiority	difficulty with decisions
violence/hostility	hypersomnia	grief/loss	racing thoughts

Other: _____

Educational History

Indicate the highest level of education/degree and/or vocational training you have completed? _____
_____
_____

Have you served in the military? __ Yes __ No Length of service: _____
Branch: _____ Type of Discharge: _____

Employment History

Current occupation: _____ Number of hours of work/week: _____
How long was your longest episode of employment? _____
What has been your usual employment pattern in the last 5 years?

__ Full time __ Part time __ Retired __ Military
__ Disability __ Student __ Unemployed __Other: _____

How many people depend on you for the majority of their financial support? _____

Substance Use History

Please indicate the frequency with which use any of the following substances:

Substance	Age of First Use	Current Use (# of days/last month)	Past Use (# of days/average month)
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Sedatives			
Cocaine			
Heroin			
Barbiturates			
Inhalants			
Hallucinogens			
Other:			

How many times have you been treated for alcohol or drug-related problems? _____

Date	Length/Type of Treatment	Length of Abstinence
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal History

Was this episode of treatment prompted by the criminal justice system? __ Yes __ No
Indicate the number of time you have been charged and/or arrested for the following:

___ Major driving violation ___ Burglary or robbery ___ Assault
___ Driving while intoxicated ___ Weapons offense ___ Drug charges
___ Disorderly conduct ___ Public intoxication ___ Shoplifting
___ Parole/probation violation ___ Contempt of court ___ Other: _____

Have you ever been incarcerated? __ Yes __ No

Date	Length of Incarceration	Reason
_____	_____	_____
_____	_____	_____

Are you presently awaiting charges, trial, or sentencing? __ Yes __ No
If yes, explain: _____

Family History

__Married (how long? _____) __ Divorced __ Separated
__Never Married __ Living together only __ Widowed

I was adopted: __ Yes __ No Please explain: _____
_____

Family Members

Name	Relationship	Age	Quality of Relationship	Living with you?
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Have you had any serious conflicts with family members in the past 30 days? __ Yes __ No
If yes, please explain: _____
Have you had any serious conflicts with family members ever? __ Yes __ No
If yes, please explain: _____

Mental Health History

Have you completed any formal psychological testing? __ Yes __ No
If yes, what were the diagnostic results? _____
Is there any family history of mental health or substance abuse problems? __ Yes __ No
If yes, please explain: _____
_____
_____

Are you currently being prescribed medication for a mental health issue? __ Yes __ No
If yes, please list name of medication and dosage as well as prescribing doctor's name:
_____
_____
Do you feel the medication is helping your symptoms? __ Yes __ No
If no, please explain: _____

How many times have you been treated for mental health in an outpatient setting? _____

Date	Reason for Treatment	Length of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many times have you been treated for mental health in an inpatient setting? _____

Date	Reason for Treatment	Length of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Would you like us to obtain your records from your previous therapists? ___ Yes ___ No

Please indicate below if you have ever experienced a significant period of:

Serious depression: ___ Yes ___ No
Please explain: _____

Serious anxiety: ___ Yes ___ No
Please explain: _____

Hallucinations/delusions: ___ Yes ___ No
Please explain: _____

Trouble understanding, concentrating, or remembering: ___ Yes ___ No
Please explain: _____

Trouble controlling aggression or violent behavior: ___ Yes ___ No
Please explain: _____

Serious thoughts of suicide: ___ Yes ___ No
Please explain: _____

Have you ever attempted suicide: ___ Yes ___ No Number of attempts: ____
Please explain: _____
_____

Has anyone ever abused you emotionally, physically, or sexually? ___ Yes ___ No
Please explain: _____
_____

Have you ever experienced or witnessed a traumatic event? ___ Yes ___ No
Please explain: _____
_____

Circle any of the following words that apply to you:

worthless	useless	a "nobody"	"life is empty"	"can't do anything right"
inadequate	stupid	incompetent	naïve	morally wrong
guilty	evil	hostile	full of hate	horrible thoughts
anxious	ugly	unattractive	repulsive	depressed
lonely	unloved	bored	restless	misunderstood
aggressive	in conflict	regrets	confused	unconfident
panicky	worried	ashamed	cowardly	unassertive

Please list as many of your strengths as possible: _____
_____

Signature: _____ Date: _____