

The LifeWorks Group, Inc.

Counseling Life History

Name: _____ Age: _____ Sex: _____

Counselor: _____

DIRECTIONS: Please answer the following questions so we can better understand your needs.
Thanks!

Problem Assessment

Present problem - "In recent months, I have worried a lot about..."

Please circle all that apply:

Marital Issues

Health Issues

Job Issues

Financial Issues

Parent/Child issues

Issues from the past (guilt, abuse, neglect, family of origin issues, etc.)

Other _____

Symptoms: *Please circle all that apply:*

Change in sleep patterns

Decreased concentration

Change in appetite

Increased anxiety

Decreased energy

Suicidal feelings

Decreased motivation

Other _____

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? yes no If yes, how?

Is there a history of suicide in your nuclear and/or extended family? yes no

Have you ever inflicted burns or wounds to yourself? yes no

Are you presently suicidal/homicidal? yes no

What event(s) in the recent past has/have prompted you to seek counseling? _____

Describe additional problems you are experiencing. _____

When did these problems develop? _____

Circle any losses you have experienced.

Family

Health

Disruption of lifestyle

Job

Significant other

Other _____

List your strengths and weaknesses.

Strengths

Weaknesses

_____	_____
_____	_____
_____	_____
_____	_____

Psychiatric History

Please list any previous outpatient counseling experiences.

Place _____

Length of time there _____ Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues?

Place _____

Length of time there _____ Dates _____

Name of current doctor and/or therapist _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. _____

Medical Information:

How would you describe your current condition of health?

Are you currently on any medication? yes no

Name of medication	Dosage/Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has it been more than a year since your last physical exam including blood test? yes no

Have you ever had an abortion? yes no

Do you have allergies? yes no If yes, explain _____

List any previous health problems, operative procedures, and medical hospitalizations:

<u>Problem</u>	<u>Dates</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Abuse History

Describe your current usage or usage within the past year (including alcohol, caffeine and tobacco).

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Age of 1st use</u>	<u>Age regular use started</u>	<u>Last use</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced a recent increase in the use of alcohol and/or other substances? yes no

Do you see your current usage as a problem? yes no If yes, when did it become problematic? _____

Please describe any previous experience with drugs or alcohol. _____

Describe any significant family history of substance abuse. _____

Nutrition:

Have your eating habits changed recently? yes no If yes, please describe _____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? yes no
Do you often eat out of depression, boredom, anger? yes no If so, please describe _____

Do you ever self-induce vomiting? yes no
How do you feel about eating with others in a group? _____
Do you ever binge eat or feel your eating is out of control? yes no If yes, please describe. _____

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them? _____

Legal History:

Please explain all that apply:

Charges as a minor _____
Charges presently _____
Arrests (how many) _____
Incarcerations (how many) _____
Parole _____
Convictions (how many) _____
Probation _____
Bankruptcy _____
Civil Suits _____
Child Custody Problems _____

Development History:

List members of your family of origin and how you get along with each one.

Family Member	Comment
_____	_____
_____	_____
_____	_____

What was your birth order? _____ of _____ children Who primarily raised you ?

How would you describe your childhood? Traumatic Lonely Uneventful Positive

What were you like as a child (include friends, school, hobbies, and personality)? _____

Were there any unusual crisis events or traumatic experiences for you as a child?

<u>Date</u>	<u>Age</u>	<u>Event</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Living Arrangements:

Satisfactory Unsatisfactory

Where do you currently live? _____ For how long?

With whom are you living?

Describe your current relationships with family members. _____

Support System:

Who can you count on for support? *Circle as many as apply:*

Parents Spouse Siblings Employer Church Co-Worker Therapist
Neighbor(s)

Extended Family Close Friend Self-help Group Community Services Pastor Medical Doctor

Other _____

Financial Situation:

Describe briefly your financial situation. _____

Marital History (if applicable):

When were you married? _____ Name and age of spouse _____
Previous marriage yes no If yes, date of divorce _____
Any children from this marriage?

What is your perception of your current marriage (include communication patterns, problems, sexual relations). _____

List names and ages of children.
one?

How do you get along with each

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Religious/ Cultural Factors:

Please list issues which are important or may have affected you in regard to religion / cultural background.

What is your religious background?

Do you currently attend church, synagogue, or mosque? yes no

Work Adjustment History:

Describe your current job/career _____

What do you like/dislike about your employment/career? Please list:

Like

Dislike

Would you enjoy doing this job on a long-term basis?

If you could have any job/career, what would you choose?

Why would you choose this?

How do you deal with authority figures? _____

Describe your relationship with co-workers

Describe your job performance

Have you ever been fired? yes no If yes, explain _____

How many jobs have you held within the previous five years?

Military History:

List branch, dates, and duties. _____

Educational History:

What was school like for you? _____

Highest level achieved? _____ What type of grades did you make?

Currently in school? yes no If yes, what level?

Family:

Would it be beneficial for any members of your family to be involved in your treatment? yes no

If yes, explain who and why.

Miscellaneous:

Are there any other things that can be helpful for us to know about you?

Signature

Date

Thank you for sharing your insights so that we may better serve you!