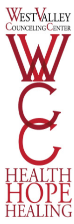

Life History Questionnaire

(All files are held in strict confidence)

First Name ________________________ MI ______ Last Name ______________________ Maiden ____________

Age _________ Date Of Birth ____________________ Gender: ☐ Male ☐ Female

Ethnicity
☐ Asian/Pacific Islander
☐ American Indian
☐ International Student Country: ____________________
☐ Caucasian
☐ Hispanic
☐ African American

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

Phone ☐ May We Leave A Message?

Email Address ☐ May We Send A Message?

☐ Work ☐ In school

Education

Employment

Hours a week you work or attend school

Please indicate who referred you to the Counseling Center

Referral Type ☐ Self ☐ Bishop ☐ Website Search ☐ Presentation
☐ Friend ☐ Other ☐ LDScounselors.net

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?
☐ 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 persisted?

Under what condition do your problems get worse? better?

Counselor Notes

Life History Questionnaire
(continued, page 2)

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, 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 stepparent(s) personality:

Briefly describe your past and current relationships with your:

Mother

Father

Stepmother

Stepfather

Spouse

Children

Religious Affiliation

☐ LDS
☐ Catholic or Jewish
☐ Protestant ________________________
☐ None, but I believe in God
☐ Atheist or agnostic
☐ Other _________________________________

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

☐ Yes ☐ No ☐ Not Sure

Please mark all of the following that apply

Feelings

- [ ] Helpless
- [ ] Depressed
- [ ] Shameful
- [ ] Angry
- [ ] Guilty
- [ ] Hopeless
- [ ] Lonely
- [ ] Sad
- [ ] Stressed
- [ ] Unhappy
- [ ] Anxious
- [ ] Out of Control
- [ ] Afraid
- [ ] Numb
- [ ] Relaxed
- [ ] Happy
- [ ] Excited
- [ ] Hopeful
- [ ] Inferiority Feeling
- [ ] Mood Shifts
- [ ] Other ___________________________________

Thoughts

- [ ] Confused
- [ ] Unintelligent
- [ ] Worthless
- [ ] Unmotivated
- [ ] Unattractive
- [ ] Unlovable
- [ ] Confident
- [ ] Worthwhile
- [ ] Homicidal
- [ ] Racing
- [ ] Obsessive
- [ ] Distracted
- [ ] Disorganized
- [ ] Paranoid
- [ ] Suicidal
- [ ] Sensitive
- [ ] Honest
- [ ] Other ___________________________________

Symptoms/Behaviors

- [ ] Eating Less
- [ ] Procrastinating
- [ ] Attempting Suicide
- [ ] Poor Concentration
- [ ] Crying
- [ ] Withdrawing Socially
- [ ] Skipping Classes
- [ ] Binge Drinking
- [ ] Injuring self
- [ ] Compulsivity
- [ ] Career/Major Choice
- [ ] Acting Out Sexually
- [ ] Acting Aggressively
- [ ] Disorganization
- [ ] Impulsivity
- [ ] Recklessness
- [ ] Irritability
- [ ] Passivity
- [ ] Drug Use
- [ ] Alcohol Use
- [ ] Being Good to Yourself
- [ ] Sexual Problems
- [ ] Socializing
- [ ] Marital Relationships
- [ ] Parent/Child Conflicts
- [ ] Lack of Ambition/Goals
- [ ] Poor Peer Relationships
- [ ] Night Mares
- [ ] Worries About Body Image
- [ ] Spiritual Problems
- [ ] Dating Concerns
- [ ] Finances
- [ ] Other ________________________

Physical Symptoms

- [ ] Insomnia
- [ ] Tired
- [ ] 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:

Anything else you would like us to know about you: