

LIFE HISTORY INVENTORY

This inventory has two purposes: 1. to allow your therapist to obtain a comprehensive picture of your background, and 2. to give you an opportunity to reflect on issues that have brought you to therapy. Please answer all questions as fully and accurately as you can. Give yourself enough time to think about them before answering. If a question does not pertain to you, put N/A ("not applicable") in the blank. This inventory is strictly confidential.

Date: _____

Name: _____ Age: _____

PRESENTING CONCERNS:

State, in your own words, your main problem(s) and how long you have had it (them): _____

Who referred you here? _____

Why did this person refer you? _____

Previous mental health professionals you have seen:

Name of Therapist, Treatment Facility, or Hospital	Dates Seen	Nature of Problem	Result of Treatment

Have you ever tried to harm yourself? _____

If yes, please list when, how, and the result. _____

Have you ever been violent toward someone else? _____ Who? _____

Describe the circumstances: _____

List any medications or prescription drugs that you currently are taking:

Medication	Dosage	Reason for medication	Compliant?

HISTORY OF CHEMICAL USE

Check all the drugs you have used:

- Alcohol Marijuana Cocaine Crack LSD
 Methadone PCP Inhalants Methamphetamine (Crystal Meth)
 Amphetamines (speed, white cross, black beauties, Molly's, etc.)
 Sedatives, Tranquilizers (sleeping pills, ludes, Valium, Xanax, Ativan, etc.)
 Barbiturates "Downers" (blue tips, reds, yellow jackets, etc.)
 Narcotics / Opiates (heroin, morphine, Dilaudid, Vicodin, etc.)
 Over-the-Counter
 Tobacco (In what form _____)

Other drugs _____
 List any current alcohol or drug use: _____
 Date of last use (which drug and when): _____
 Frequency of use: _____
 Previous chemical dependency assessment or treatment? _____ If so, where, when, and did you complete treatment? _____
 Have you ever attended AA? _____ NA? _____ Al-Anon? _____ ACOA? _____

MEDICAL HISTORY

Height: _____ Weight: _____
 Activity level? _____ Low _____ Moderate _____ Active
 How is your health? _____ Poor _____ Fair _____ Good _____ Excellent
 Describe any serious illnesses or medical conditions you have or have had: _____

Describe any accidents or operations you have had at any time of your life: _____

Describe any health problems you have had within the last 60 days, such as dizziness, fainting, vomiting, diarrhea, vision changes, dental problems, sleep problems, etc.: _____

Physician's name, address, and phone number: _____

When did you last see a physician for any reason? _____ Why? _____

List problems during your mother's pregnancy, labor, and/or delivery, as well as any developmental delays you had: _____

Have any of the following event happened recently:

Death in family Death of friend Death of pet Move
 Separation/divorce Employment change Abuse of child Domestic violence
 Other significant life event(s): _____

FAMILY HISTORY

Please list people who currently reside in your home:

Name	Age	Relationship to Client	Occupation	How you get along

Please list significant family members or people in your life who do not reside in your home:

Name	Age	Relationship to Client	Occupation	How you get along

Family of Origin

Family Member	Name	Age	Education	Occupation	How you get along	Alcohol/drug problems	Mental health problems	Health problems
Mother								
Father								
Step-mother								
Step-father								
Sibling								
Sibling								
Sibling								

If your parents are living, what is the state of their health?

Mother: _____ Father: _____

Date and cause of death: Mother _____ Father: _____

If your parents did not raise you, who did? _____

What is/was your relationship like with that person(s)? _____

Is there any other information about yourself or your family of origin that is relevant to your therapy? If yes, please describe: _____

MARITAL / RELATIONSHIP HISTORY

Single / never married
 Married
 Engaged
 Widowed
 Living together
 Separated
 Divorced

Name of spouse / current partner: _____

How long have you been together? _____

Describe your relationship with your spouse / partner: _____

Have you ever been separated? _____ How many times? _____ How long? _____

Reason(s) for separation? _____

Have you ever been divorced? _____ How many times? _____

Reason(s) for the divorce(s)? _____

Has your current spouse / partner been married before? _____ How many times? _____

Reasons for the divorce(s)? _____

Do your children live with you? _____ If not, with whom do they live? _____

Do you have shared parenting? _____ Visitation? _____

Any concerns about your children or parenting your children? If yes, please explain. _____

EDUCATIONAL HISTORY

Less than high school graduate (highest grade completed _____)
 High school graduate
 GED (last grade completed _____)
 Associates degree or some college
 College degree, specify _____

_____ Vocational, technical, or business training _____
_____ Currently in school (where? _____)

Check any problems you experienced in school:

_____ Missing/skipping class _____ Tardiness _____ Low grades _____ Held back a grade
_____ Suspended/expelled _____ Problems reading/writing _____ Problems with other students
_____ Problems with teachers/professors _____ Other, describe _____

Describe your academic abilities, strengths, and weaknesses _____

VOCATIONAL HISTORY

Please list your job history. Include dates of employment, name of employer, and what you did. _____

Please list current employment, if applicable. _____
Are you satisfied or unsatisfied with current work? _____ List reasons: _____

Does your income meet your financial needs? _____ Why or why not? _____

LEGAL HISTORY

Have you ever had trouble with the law? If so, please explain. _____

Current involvement in the legal system (criminal, civil, juvenile, etc.)? If so, please explain. _____

RELIGIOUS HISTORY

Please describe your religious/spiritual beliefs or religion: _____

Do you attend a church, temple, mosque, etc.? _____ How often? _____
Did you attend as a child? _____ How often? _____
How important is your faith to you? _____
Religious/spiritual background of spouse/partner: _____
Do you and your partner agree on religious/spiritual issues/beliefs? _____

SEXUAL HISTORY

What were your parents'/caregivers' beliefs/attitudes about sex? _____

Was sex discussed with you as a child? _____
If not, how did you derive your knowledge of sex? _____
When did you first become aware of your sexual impulses? _____
Have you experienced guilt or anxiety arising from your sexual activities? _____
At what age did you have your first sexual experience? _____
Give details about sexual experiences you have had that you consider relevant to your therapy: _____

Are you satisfied with your current sex life? _____
Have you ever been sexually abused or assaulted? _____ By whom? _____
When? _____ Was this reported? _____
What was the result of the report? _____

****For Females:** Age of first period? _____ Number of pregnancies? _____ Number of deliveries? _____
Number of miscarriages? _____ Number of abortions? _____ Given a baby up for adoption? _____
Were you involved in the adoption decision? _____

****For Males:** How many children have you fathered? _____ Did the mother(s) deliver the baby? _____
Miscarry? _____ Abortion? _____ Give baby up for adoption? _____ Were you involved in the decisions? _____

PRESENT LIFE

How do you spend your free time? _____
Do you have friends? _____ Do you make friends easily? _____ Do you maintain friendships? _____
Who are the most important people in your life? _____
How often do you spend time or communicate with these people? _____
If you have children, are you satisfied with your relationship with them? Explain. _____

Please complete the following:

I am _____

I feel _____

I think _____

I wish _____

My five main fears are: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Describe your earliest memory? _____

Check any that apply to you:

<input type="checkbox"/> Palpitations	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fatigue	<input type="checkbox"/> No appetite	<input type="checkbox"/> Tense	<input type="checkbox"/> Tremors	<input type="checkbox"/> Depressed
<input type="checkbox"/> Conflict	<input type="checkbox"/> Allergies	<input type="checkbox"/> Lonely	<input type="checkbox"/> Shy	<input type="checkbox"/> Anger
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug use	<input type="checkbox"/> Can't relax	<input type="checkbox"/> Suicidal	<input type="checkbox"/> No friends
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Financial issues	<input type="checkbox"/> Stomach issues	<input type="checkbox"/> Panicky	<input type="checkbox"/> Sex issues
<input type="checkbox"/> Can't keep job	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Inattention	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Other: _____				

EXPECTATIONS FOR THERAPY

What about your present behavior do you want to change? _____

What feelings to you want to alter? _____

What benefits to you expect to get from therapy? _____

What characteristics are you seeking in a therapist? _____

How long do you think your therapy should last? _____

What do you think therapy is about? _____

To whom can you turn for personal support? _____

Will you be able to hold yourself accountable while trying to make changes? _____

Questions you have about therapy or your therapist? _____

Other information you think is pertinent for your therapist to know? _____