MENTAL HEALTH SYSTEMS

Elizabeth POTTER

LIFE HISTORY QUESTIONNAIRE

NAME: ________________________________ DOB: _________________ Date: ________________

Who referred you? ____

What is your place of employment and /or school you are attending?

____

What is your occupation and job title or grade in school?

____

Who are the people living you your home now? Please list and state relationship to you.

____

____

____

PRESENT PROBLEM/REASON FOR SEEKING TREATMENT:

State in your own words why you are coming to therapy now. What are the problems you want to work on here and what are your goals? Continue on reverse side if needed.

____

____

A. PSYCHIATRIC HISTORY

If you have ever been in psychotherapy or psychiatric treatment before, please list the name and locations of the facilities, hospitals, dates of treatment, and the type of therapy you received.

Please describe your experience:

____

____

MENTAL HEALTH SYSTEMS

Elizabeth POTTER

B. SOCIAL HISTORY

1. Briefly describe your job history: ____

____

2. How is most of your free time occupied? ____

____

3. Current religious preference (optional): ____

What is your family's religious background? ____

____

4. Where were you born and raised? ____

SCHOOL HISTORY:

1. Did you graduate high school? ______ What year?_____________

2. Name of High School?_________________________

3. College Participation?__________________ Years attended and Major?___________________________

4. Post College Experience?___________________________

PARENTS:

Father: Place of Birth ____________________ If alive, age: ______ Occupation:______________________

If deceased, cause: ____ Your age at time of his death:_____

MENTAL HEALTH SYSTEMS
Elizabeth POTTER

Brief description of his personality:
____

____

Mother: Place of Birth ___________________ If alive, age:______Occupation:_____________________

If deceased, cause: ____ Your age at time of her death: ____

Brief description of her personality:
____

____

6. List names, ages and sex of brothers and sisters:
____

____

7. List name, birth date and sex of each of your children:
____

____

8. Who are the most important people in your life now?
____

____

9. Relationship history: Please give the dates of each significant relationship and give a brief description of each spouse/partner:

____

____

10. Please list any events or conditions that were important in your childhood or teenage years:
____

____

____

____

11. Please describe your experience in school (friends, grades, activities, sports, clubs):
____

____

12. Check any of the following that apply to you:

A. As a child **B. As an adult**

Adopted _______ Sibling died/other _______ significant losses ________

Served in military ____ Parents did not speak English __Sexually molested or assaulted______

Arrested _______ Family moved more than three times _________

Physically abused or assaulted ______ Death of a child/other significant losses ______

Lived away from home _________ Arrested _______

Sexually assaulted ____Parents separated _______ Emotionally abused _______

Physically abused or assaulted ________Parents divorced _______

Neglected _______ Emotionally abused _______

C. MEDICAL HISTORY

Are you currently pregnant? Yes _______ No _______

Please list your childhood illnesses (i.e. rheumatic fever, measles, etc.):

____

Please list hospitalizations and surgeries, giving diagnoses and dates:

____

MENTAL HEALTH SYSTEMS
Elizabeth POTTER

Have you ever had any of the following?

	No	Yes	Date of Onset	Check if still a problem		No	Yes	Date of Onset	Check if still a problem
Cancer					Hormonal Concerns				
Eye Trouble					Chronic Illness				
Diabetes					Neurological Disease				
Heart Trouble					Kidney Trouble				
Thyroid					Head Injury				
Epilepsy/Seizures					Miscarriage				
Head Injury					Abortion				
HIV Positive					Allergies				
High Blood Pressure					Other				

Check any of the following symptoms which apply to you:

Hair loss _____ Fast heartbeat _____ Tremors _____ Weight gain _____
Diarrhea _____ Excessive fluid intake _____ Fatigue _____ Headaches _____
Blurred vision _____ Constipation _____ Dizziness _____ Impaired hearing _____
Dry skin _____ Fainting spells _____ Ringing in the ears ___ Weakness _____
Shortness of breath ___Chest pain _____ Weight loss _____ Indigestion _____
Tingling of hands/feet _____ Ankle swelling _____
Sexual organ problems _____ Nausea or vomiting _____
Urinary problems _____ Difficulty sleeping _____ Menstrual problems _____
Increased appetite _____ Sleeping too much _____ Date of last menstrual period _____

List any other allergies:

____

MENTAL HEALTH SYSTEMS

Elizabeth POTTER

Is your diet unusual in any way? If so, how?
____

Do you have any other physical symptoms about which you are concerned?
____

____

Please list all medications which you are currently taking:

____

Name of Medication Dosage Prescribed by _____________________________
_________________________ ________________________________ _____________________________
_________________________ ________________________________ _____________________________
_________________________ ________________________________ _____________________________

PHYSICAL EXAMINATION:

Date of last physical exam: ______________ Name of M.D.:______________________________________

(I encourage you to contact your physician about any health problems you may have.)

E. MEDICAL AND/OR PSYCHIATRIC PROBLEMS IN YOUR FAMILY

Has anyone in your family had psychological/psychiatric problems? If so, please describe.
____
____
____

Have any of your relatives committed suicide? (specify)
____
____

Have any of your blood relatives (even if distant) suffered from any of the following illnesses?

	NO	YES	RELATIONSHIP		NO	YES	RELATIONSHIP
Cancer	_____	_____	_______________________	Alcoholism	_____	____	_____________________
Diabetes	_____	_____	______________________	Drug Addiction	_____	_____	________________

MENTAL HEALTH SYSTEMS
Elizabeth POTTER

Thyroid Problems _____ _____ _______________

Other Hormonal Illness _____ _____ _________

Allergies _____ _____ _______________________

Neurological Disease _____ _____ ___________

Epilepsy or seizures _____ _____ ____________

Other serious illness (specify) _____ _____ ___

D. MEDICATION, DRUG AND ALCOHOL USE : Because many drugs have psychological effects, it is important for me to know what drugs you are currently taking and/or have taken in the past. This information will remain strictly confidential. Please include both illegal and legal drugs including caffeine, nicotine, alcohol, pain medication, etc., noting frequency and amount.

Drug Name (Specify)	Frequency	Amount	Age of 1st use	Indicate current (C) or past (P) Use	Drug Name (Specify)	Frequ-ency	Amount	Age of 1st Use	Indicate current (C) or Past (P) Use
SLEEPING MEDICATION ____________ ____________					Cigarettes _________ _________ _________				
Anti-Anxiety ____________ ____________					Alcohol __________ __________				
Tranquilizers / Anti-Psychotics ____________ ____________					Marijuana __________ __________ __________ __________				

MENTAL HEALTH SYSTEMS
Elizabeth POTTER

Drug Name (Specify)	Frequency	Amount	Age of 1st use	Indicate current (C) or past (P) Use	Drug Name (Specify)	Frequ-ency	Amount	Age of 1st Use	Indicate current (C) or Past (P) Use
Barbiturates ___________ ___________					Inhalants __________ __________				
Anit-Convulsants ___________ ___________					Anti-Manic __________ __________				
Pain Medication ___________ ___________					Anti-Parkinsonism ____________ ____________				
Ampheta-mines ___________ ___________					Steroids ____________ ____________				
Cocaine ____________ ____________					Thyroid ____________ ____________				
Heroin ___________ ___________					Blood Pressure ____________ ____________				
Birth Control ___________ ___________					Other (Specify) ____________ ____________				

What drugs have you ever injected?____

Have you ever had a drug or alcohol related arrest? Yes _____ No _____

Have you ever had blackouts from drugs or alcohol? Yes _____ No _____

MENTAL HEALTH SYSTEMS

Elizabeth POTTER

Is there anything else that would be helpful for me to know about you?
____
____
____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Elizabeth A. Potter, LIMP, LADC, P.C. Clinical Therapist/Supervising Practitioner