Melanie K. Young, Psy.D.
Licensed Psychologist
2501 Walnut Street, Suite 208
Boulder, CO 80302
303-444-5330

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: _____

_____

_____

Have you ever made a suicide attempt? _____ If so, explain: _____

_____

_____

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? _____

5. Parents:

Father: Place of Birth _____ If alive, age: _____ Occupation: _____

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

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. <u>As a child</u>

Adopted	_____	Sibling died/other significant losses	_____		
Parents did not speak English	_____	Sexually molested or assaulted	_____		
Family moved more than three times	_____	Physically abused or assaulted	_____		
Lived away from home	_____	Arrested	_____		
Parents separated	_____	Emotionally abused	_____		
Parents divorced	_____	Neglected	_____		

B. <u>As an adult</u>

Served in military	_____
Arrested	_____
Death of a child/ other significant losses	_____
Sexually assaulted	_____
Physically abused or assaulted	_____
Emotionally abused	_____

C. <u>MEDICAL HISTORY</u>

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:

_____

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					Eye Trouble				
Diabetes					Heart Trouble				
Thyroid Trouble					Epilepsy/Seizures				
Other Hormonal Illness					Neurological Disease				
Kidney Trouble					Head Injury				
Abortions					HIV Positive				
Miscarriages					Allergies (especially to medication)				
High Blood Pressure									

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: _____

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*.)

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 FIRST USED	INDICATE CURRENT (C) AND/OR PAST (P) USAGE	DRUG NAME (Specify)	FREQUENCY	AMOUNT	AGE FIRST USED	INDICATE CURRENT (C) AND/OR PAST (P) USAGE
SLEEPING MEDICATION					CIGARETTES				
ANTI-ANXIETY					ALCOHOL				
TRANQUILIZERS/ ANTI-PSYCHOTICS					MARIJUANA				
ANTI-DEPRESSANTS/ MOOD ELEVATORS					HALLUCINOGENS				
BARBITURATES					INHALANTS				
ANTI-CONVULSANTS					ANTI-MANIC				
PAIN MEDICATION/ OTHER OPIATES/SYNTHETICS					ANTI-PARKINSONISM				
AMPHETAMINES					STEROIDS				
COCAINE					THYROID				
HEROIN					BLOOD PRESSURE				
BIRTH CONTROL					OTHER (SPECIFY)				

What drugs have you every injected? _____

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

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

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	____	____	_____
Thyroid Problems	____	____	_____	Neurological Disease	____	____	_____
Other Hormonal Illness	____	____	_____	Epilepsy or seizures	____	____	_____
Allergies	____	____	_____	Other serious illness (specify)	____	____	_____

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

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Melanie K. Young, Psy.D.
Licensed Clinical Psychologist