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## Life History Questionnaire – Adult

The purpose of this questionnaire is to obtain a comprehensive picture of your background. These records are necessary as they permit a more thorough understanding of your issues/concerns. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. We request that you answer these routine questions prior to your first visit to our office.

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. **Case records are strictly confidential. No outsider is permitted to see your case record without your permission.** If you do not wish to answer any of the questions, please write “Do not care to answer” in the area next to the question.

Date: \_\_\_\_\_

### I. GENERAL

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DAYTIME NUMBER: \_\_\_\_\_ EVENING NUMBER: \_\_\_\_\_

AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

BY WHOM WERE YOU REFERRED? \_\_\_\_\_

WITH WHOM ARE YOU NOW LIVING? (LIST PEOPLE)

\_\_\_\_\_  
\_\_\_\_\_

DO YOU LIVE IN A HOUSE, HOTEL, ROOM, APARTMENT, ETC? \_\_\_\_\_

MARITAL STATUS:

SINGLE

ENGAGED

MARRIED

REMARIED

SEPARATED

DIVORCED

WIDOWED

COHABITATING

CIVIL COMMITMENT

SPOUSE/PARTNER'S NAME, AGE, OCCUPATION?

\_\_\_\_\_

RELIGION AND ACTIVITY:

A.) IN CHILDHOOD: \_\_\_\_\_

B.) AS AN ADULT: \_\_\_\_\_

## II. CLINICAL

A.) State in your own words the nature of your current problems:

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B.) Give a brief account of the history and development of your complaints (from onset to present):

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C.) On the scale below please estimate the severity of your problem(s):

Mildly upsetting \_\_\_\_\_

Moderately severe \_\_\_\_\_

Very severe \_\_\_\_\_

Extremely severe \_\_\_\_\_

Totally incapacitating \_\_\_\_\_

D.) History of outpatient therapy, inpatient hospitalization and psychiatric treatment:

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E.) Are you taking any medication?            YES            NO

If yes, what, how much, and with what results? \_\_\_\_\_

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## III. PERSONAL DATA

A. Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

B. Mother's condition during pregnancy (to your knowledge): \_\_\_\_\_

C. Check any of the following that applied during your childhood:

Night terrors

Bedwetting

Sleepwalking

Thumb sucking

Nail biting

Stammering

Fears

Happy childhood

Unhappy childhood

Any others: \_\_\_\_\_

D. Health during childhood/Developmental Development/Milestones:

List illnesses:

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E. Health during adolescence:

List illnesses:

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F. What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_

G. Any surgical operations? (Please list them and give age at the time).

OPERATION	AGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

H. Any accidents? Any TBI? \_\_\_\_\_

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I. List your five main fears:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

J. Circle any of the following that apply to you:

- |                                   |                      |                    |                            |
|-----------------------------------|----------------------|--------------------|----------------------------|
| Headaches                         | Dizziness            | Fainting spells    | Palpitations               |
| Stomach trouble                   | Anxiety              | Bowel disturbances | Fatigue                    |
| No appetite                       | Anger                | Take sedatives     | Insomnia                   |
| Nightmares                        | Feel panicky         | Alcoholism         | Feel tense                 |
| Conflict                          | Tremors              | Depressed          | Suicidal ideas             |
| Take drugs                        | Allergies            | Lonely             | Unable to relax            |
| Sexual problems                   | Overambitious        |                    | Shy with people            |
| Don't like weekends and vacations |                      |                    | Can't make friends         |
| Can't make decisions              | Inferiority feelings |                    | Can't keep a job           |
| Home conditions bad               | Memory problems      |                    | Financial problems         |
| Excessive sweating                | Often use aspirin    |                    | Concentration difficulties |

Others: Please list additional chronic health problems or difficulties: \_\_\_\_\_

K. Military Experience: \_\_\_\_\_

L. Check any of the following words which apply to you:

	Worthlessness		Useless		A "nobody"		"Life is empty"		Goal directed		Ethical
	Inadequate		Stupid		Incompetent		Naïve		"Can't do anything right"		Lovable
	Guilty		Evil		Morally wrong		Horrible thoughts		Hostile		Full of hate
	Anxious		Agitated		Cowardly		Unassertive		Panicky		Aggressive
	Ugly		Deformed		Unattractive		Repulsive		Assertive		Good worker
	Depressed		Lonely		Unloved		Misunderstood		Bored		Restless
	Confused		Unconfident		In conflict		Full of regrets		Calm		Helpful
	Worthwhile		Sympathetic		Intelligent		Attractive		Confident		Considerate
	Honest		Social		Friendly						

Others: \_\_\_\_\_

L. Present interests, hobbies, and activities: \_\_\_\_\_

M. How is most of your free time occupied? \_\_\_\_\_

N. Highest level of education, school name and graduation date? \_\_\_\_\_

O. Scholastic abilities—strengths and weaknesses: \_\_\_\_\_

P. Were you ever bullied or severely teased? \_\_\_\_\_

Q. Do you make friends easily? \_\_\_\_\_

Do you keep them? \_\_\_\_\_

R. History of arrests, incarcerations, lawsuits, legal issues: \_\_\_\_\_

#### IV. OCCUPATIONAL DATA

A. What sort of work are you doing now? \_\_\_\_\_

B. Kinds of jobs held in the past? \_\_\_\_\_

C. Does your present work satisfy you? (If not, in what ways are you dissatisfied?)

D. What do you earn? \_\_\_\_\_

How much does it cost you to live? \_\_\_\_\_

E. Ambitions: \_\_\_\_\_

Past: \_\_\_\_\_

Present: \_\_\_\_\_

## **V. SEX INFORMATION**

A. Parental attitudes toward sex (e.g., was there sex instruction or discussion in the home?)

\_\_\_\_\_

B. When and how did you derive your first knowledge of sex? \_\_\_\_\_

\_\_\_\_\_

C. When did you first become aware of your own sexual impulses? \_\_\_\_\_

\_\_\_\_\_

D. Did you ever experience any anxieties or guilt feelings arising out of sex or masturbation? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

E. Any relevant details regarding your first or subsequent sexual experience:

\_\_\_\_\_

\_\_\_\_\_

F. Is your present sex life satisfactory? (If not, please explain). \_\_\_\_\_

\_\_\_\_\_

G. Provide information about any significant heterosexual and/or homosexual reactions:

\_\_\_\_\_

\_\_\_\_\_

H. Are you sexually inhibited in any way? \_\_\_\_\_

## **VI. MENSTRUAL HISTORY**

Age at first period? \_\_\_\_\_

Were you informed or did it come as a shock? \_\_\_\_\_

Are you regular? \_\_\_\_\_ Duration: \_\_\_\_\_

Do you have pain? \_\_\_\_\_ Date of last period: \_\_\_\_\_

Do your periods affect your moods? \_\_\_\_\_

## VII. MARITAL HISTORY OR HISTORY WITH PARTNER (Civil Union /Cohabiting)

How long did you know your partner before engagement? \_\_\_\_\_

How long have you been married/cohabitating? \_\_\_\_\_

Partner's age: \_\_\_\_\_ Partner's Occupation: \_\_\_\_\_

A. Personality of partner (in your own words): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. In what areas are you compatible? \_\_\_\_\_

\_\_\_\_\_

C. In what areas are you incompatible? \_\_\_\_\_

\_\_\_\_\_

D. How do you get along with your partner's family? (This includes their brothers & sisters)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. How many children do you have? \_\_\_\_\_

Please list their name(s), sex and age(s):

NAME	SEX	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

F. Do any of your children present special problems? \_\_\_\_\_

\_\_\_\_\_

G. Comments about any previous marriage(s) and brief details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## VIII. FAMILY DATA

A. Father:

Living or Deceased? \_\_\_\_\_ If deceased, age at time of death? \_\_\_\_\_

Cause of death? \_\_\_\_\_

If alive, father's present age? \_\_\_\_\_ Occupation: \_\_\_\_\_

Health: \_\_\_\_\_

B. Mother:

Living or Deceased? \_\_\_\_\_ If deceased, age at time of death? \_\_\_\_\_

Cause of death? \_\_\_\_\_

If alive, mother's present age? \_\_\_\_\_ Occupation: \_\_\_\_\_

Health: \_\_\_\_\_

Step Mother, Step Father (circle)

Living or Deceased? \_\_\_\_\_ If deceased, age at time of death? \_\_\_\_\_

Cause of death? \_\_\_\_\_

If alive, step parent's present age? \_\_\_\_\_ Occupation: \_\_\_\_\_

Health: \_\_\_\_\_

C. Siblings:

Number of brothers: \_\_\_\_\_ AGE(S): \_\_\_\_\_

Number of sisters: \_\_\_\_\_ AGE(S): \_\_\_\_\_

D. Relationship with brothers and sisters:

1) Past:

\_\_\_\_\_  
\_\_\_\_\_

2) Present:

\_\_\_\_\_  
\_\_\_\_\_

E. Give a description of your father's personality/attitude toward you (past and present):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Give a description of your mother's personality/attitude toward you (past and present):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

G. In what ways were you punished by your parents as a child? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

H. Give an impression of your home atmosphere (i.e., the home in which you grew up. Mention state of compatibility between parents and between parents and children).

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I. Were you able to confide in your parents? \_\_\_\_\_

J. Did your parents understand you? \_\_\_\_\_

K. Basically, did you feel loved and respected by your parents? \_\_\_\_\_

L. Give an outline of your religious training: \_\_\_\_\_

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M. If you were not raised by your parents, who raised you and between what years?

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N. Has anyone (parents, relatives, friends) ever interfered in your marriage, relationship, occupation, etc? \_\_\_\_\_

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O. Who are the most important people in your life? \_\_\_\_\_

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P. Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"? \_\_\_\_\_

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Q. Are there any other members of the family about whom information regarding illness, etc., is relevant?

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R. Recount any fearful or distressing experiences not previously mentioned:

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S. List the benefits you hope to derive from therapy. \_\_\_\_\_

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T. List any situations which make you feel calm or relaxed. \_\_\_\_\_

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U. Have you ever lost control (e. g., temper, crying or aggression)? If so, please describe:

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V. Please add any information not included in this questionnaire that may aid your therapist in understanding and helping you. \_\_\_\_\_

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**IX. SELF-DESCRIPTION (Please complete the following):**

A. I am a person who \_\_\_\_\_

B. All my life \_\_\_\_\_

C. Ever since I was a child \_\_\_\_\_

D. One of the things I feel proud of is \_\_\_\_\_

E. It's hard for me to admit \_\_\_\_\_

F. One of the things I can't forgive is \_\_\_\_\_

G. One of the things I feel guilty about is \_\_\_\_\_

H. If I didn't have to worry about my image \_\_\_\_\_

I. One of the ways people hurt me is \_\_\_\_\_

J. Mother was always \_\_\_\_\_

K. What I needed from mother and didn't get was \_\_\_\_\_

L. Father was always \_\_\_\_\_

M. What I wanted from my father and didn't get was \_\_\_\_\_

N. If I weren't afraid to be myself, I might \_\_\_\_\_

O. One of the things I'm angry about is \_\_\_\_\_

P. What I need and have never received from a woman/man is \_\_\_\_\_

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Q. The bad thing about growing up is \_\_\_\_\_

R. One of the ways I could help myself but don't is \_\_\_\_\_

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**X. SELF-DESCRIPTION, PART II**

A. What would you like to change about your present behavior?

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B. What feelings do you wish to change (e.g., increase or decrease)?

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C. What sensations are especially:

a. Pleasant for you? \_\_\_\_\_

b. Unpleasant for you? \_\_\_\_\_

D. Describe a very pleasant image or fantasy.

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E. Describe a very unpleasant image or fantasy.

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F. What do you consider your most irrational thought or idea?

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G. Describe any interpersonal relationships that give you:

a. Joy:

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b. Grief:

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H. What personal characteristics do you think the ideal therapist should possess?

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I. How would you describe an ideal therapist's interactions with his/her client?

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J. What do you think therapy will do for you and how long do you think your therapy should last? \_\_\_\_\_

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K. In a few words, what do you think therapy is all about? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **XI. SELF-DESCRIPTION, PART III**

With the remaining space, please provide a word/picture of yourself as described:

A. By yourself: \_\_\_\_\_

B. By your partner (if married): \_\_\_\_\_

C. By your best friend: \_\_\_\_\_

D. By someone who dislikes you: \_\_\_\_\_