# Life History Self-Report Form Adult

The purpose of this form is to obtain a comprehensive understanding of you—your life experience and background. In answering the following questions as accurately and completely as you can, you will facilitate in the development of a treatment plan that is best suited to your individual needs.

**Please print clearly. If you need more space for any of the questions, please use the back of the sheet.**

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

**Ok to leave message?** Home: ☐ Yes ☐ No Work: ☐ Yes ☐ No Cell: ☐ Yes ☐ No

Email address (optional): _____

Ok to send mail? Home: ☐ Yes ☐ No Email: ☐ Yes ☐ No

Birth date _____/_____/_____ Age _____ Gender ☐ F ☐ M

**Race:** ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Caucasian ☐ Other _____

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of divorce _____

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

**Household**

Do you live alone? ☐ Yes ☐ No If No, who else resides in the home? _____

_____

**Work History**

Current Employment Status:

☐ FT ☐ PT ☐ Laid-off ☐ Disabled ☐ Retired ☐ Social Security ☐ Student ☐ Other: _____

What type of work do you do? _____ Current Employer: _____

Length of time with current employer? _____

Employment status and type of work of your significant other? _____

**Presenting Problem**
What is the presenting problem (reason for seeking assistance)? _____

_____

_____

When did the problem begin? _____

_____

**Counseling History**
Have you ever sought help from a counselor, psychologist, psychiatrist, pastor, or other professional?

☐ Yes ☐ No If *Yes*: where, when, and for what? _____

_____

_____

Was it helpful? ☐ Yes ☐ No Explain: _____

Have you ever been hospitalized for emotional reasons? ☐ Yes ☐ No If *Yes*, please explain _____

_____

_____

Have you ever had thoughts of suicide (killing yourself)? ☐ Yes ☐ No
If *Yes*, when? _____

Have you ever planned or taken any action toward ending your life? ☐ Yes ☐ No If *Yes*, please explain:

_____

Have you ever had the thought or plan to commit homicide (killing someone else)? ☐ Yes ☐ No
If *Yes*, please explain:

_____

Do you feel suicidal or homicidal at this time? ☐ Yes ☐ No If Yes, explain _____

_____

**Trauma History**
Are there traumatic, unusual, or special circumstances that occurred in your life? ☐Yes ☐No

Has there been a history of child abuse? ☐Yes ☐No
If *Yes*, please describe _____

_____

**Family Psychiatric History**
Does anyone in your family suffer from a mental or emotional disorder (depression, anxiety, alcoholism, schizophrenia, etc.)? ☐ Yes ☐ No If Yes, please explain: _____

_____

Has any one of your relatives ever attempted or committed suicide? ☐ Yes ☐ No If so, who?

_____

**Medical History**
How do you rate your present physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any medical problems you are currently experiencing: _____
_____
_____

List all medications you are currently taking:

| Name of Medication | Dosage | Frequency | Reason for use |
|---|---|---|---|
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**Substance Use History**
Please list any recreational chemicals that you currently use or have used in the past (alcohol, marijuana, cocaine, crack, sedatives, tranquilizers, painkillers, barbiturates, heroin, ecstasy, hallucinogens, etc.)
_____

Current substance of preference: _____

When and where was your last drink/drug use? _____ How much? _____

Check the items below that describe your present drinking/drug use pattern:

☐ No use
☐ Regularly (daily)
☐ Heavy (daily)
☐ Irregular & excessive
☐ Short binges (1-2 days)
☐ Long binges (4+ days)
☐ Rarely (once a month)
☐ Only on holidays
☐ Occasionally (weekends)

Have you ever received professional treatment for drug/alcohol problem (include AA)? ☐Yes ☐No
If *Yes*, when? _____

Nature of treatment: ☐ Inpatient ☐ Outpatient ☐ Detoxification ☐ Self-help

Has anyone ever expressed concern about your drinking/drug abuse? ☐Yes ☐No
If *Yes*, explain: _____

**Personal Strengths and Weaknesses**
Name three strengths and one weakness: _____
_____
_____
_____

**Family History**

| Relationship | Name | Age | Living? If No, what was the cause of death, year, and age | Currently living with you? Y or N | Step or Adopted Y or N |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Children: | | | | | |
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| Mother | | | | | |
| Father | | | | | |
| Step-Parent | | | | | |
| | | | | | |
| Siblings | | | | | |
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Parents: ☐ Married ☐ Divorced (Your age at time of divorce: _____) ☐ Separated ☐ Living Together

Were you adopted? ☐ Yes ☐ No If *Yes*, from what age did you know? _____
If you were not brought up by your parents, who raised you? Between what years? _____
_____

Father's Occupation: _____ Mother's Occupation: _____

How would you describe your relationship with your parents and siblings? Is there anyone that you are particularly distant from, close with or have problems with? _____
_____

**Social Relationships**
How do you describe your interactions with others?

☐ Leader ☐ Follower ☐ Friendly ☐ Outgoing ☐ Shy ☐ Uncomfortable ☐ Guarded ☐ Aggressive
☐ Affectionate ☐ Withdrawn ☐ Submissive ☐ People Pleaser ☐ Bossy Other _____

Do you have supportive family and friends? ☐ Yes ☐ No

Do you have a history of social problems? ☐ being bullied ☐ bullying others ☐ being abused ☐ abusing others
If so, what type of abuse (circle all that apply): emotional, sexual, physical, verbal

**Developmental History**
Did your mother experience any problems during her pregnancy or delivery with you? ☐ Yes ☐ No If Yes, please explain: _____

Did you reach developmental milestones normally? ☐ Yes ☐ No If the response is No, please explain:

_____

**Education**
What is the highest grade of school you completed? _____

Are you in school Now? ☐ Yes ☐ No If *Yes*, where? _____ Major? _____

Technical training: _____

**Military**
Military service? ☐Yes ☐ No Branch _____ # of Tours _____ Combat experience? ☐ Yes ☐ No

Discharge date _____ Type of Discharge _____ Rank at Discharge _____

Do you have family members in the service? ☐ Yes ☐ No Who? _____

**Current Legal Status and History**
Are you involved in any active court cases? (traffic, civil, criminal)? ☐ Yes ☐ No

If *Yes*, please describe and indicate court and hearing/trial dates and charges _____
_____

Are you currently on parole or probation? ☐Yes ☐No

If *Yes*, please describe _____

Have you ever had any traffic violations due to a DWI, DUI, OWI, etc. in the past? ☐ Yes ☐ No

**Sleep Habits**
How many hours of sleep do you receive in a typical night? _____ Hours
Any problems: ☐ Falling asleep ☐ Staying asleep

**Spiritual/Religious**
How important are spiritual matters to you? ☐ Not at all ☐ Somewhat ☐ Important ☐ Very Important

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No
If *Yes*, describe _____

Were you raised with a spiritual/religious upbringing? ☐ Yes ☐ No
If *Yes*, describe _____