Adult Life History Questionnaire

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Legal Name:

Preferred Name:

Age: Date of Birth: / /

Sex Assigned at Birth: M F Intersex

Gender: M F Other:

Pronouns: He/Him/His She/Her/Hers They/Their/Theirs Other:

Do you have a faith-based or spiritual practice?

Address:

Phone number(s)/Email address:

Emergency Contact:

Marital Status: Single Married Divorced Separated Remarried Committed relationship Partnered Widowed

Education/Highest Grade Completed:

Occupation/Employer:

Presenting problem/reason for seeking treatment:

Besides therapy, how have you tried to manage this problem?

Previous Psychiatric Treatment: None Outpatient Inpatient

 If applicable, please describe reason for treatment, clinic, dates of treatment, and outcomes:

Psychiatrist’s Name: Psychiatrist’s Phone #:

Physician’s Name: Physician’s Phone #:

Medical conditions:

Allergies:

Medications:

Symptom Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Victim of abuse |  | Compulsive spending |  |
| Neglect |  | Compulsive sexual relationships |  |
| Unresolved grief/loss |  | Weight loss/gain |  |
| Irritability |  | Binge eating |  |
| Loss of enjoyment of usual activities |  | Not eating to lose weight |  |
| Low self-esteem |  | Trying to lose weight by vomiting or exercising excessively  |  |
| Tiredness, fatigue |  | Feelings of detachment |  |
| Withdrawn, isolation |  | Hearing voices |  |
| Feelings of emptiness |  | Excessive physical pain |  |
| Difficulty sleeping |  | Seeing things that aren’t there |  |
| Panic, panic-attacks |  | Hair-pulling, picking at skin |  |
| Expressing a wish to die |  | Impulsivity |  |
| Poor concentration |  | Disorientation |  |
| Excessive worry |  | Difficulty finishing tasks |  |
| Thoughts/attempts of suicide |  | Difficulty paying attention |  |
| Excessive fears (phobias) |  | Excessive daydreaming |  |
| Nervousness |  | Stealing |  |
| Workaholic behavior |  | Lying |  |
| Repeating an act over and over that is unnecessary (e.g. washing, counting) |  | Hyperactivity |  |
| Excessive need for order, cleanliness |  | Recurring problems with the law |  |
| Overly concerned with details |  | Destroying property |  |
| Easily annoyed |  | Cigarette use |  |
| Mood swings |  | Alcohol use |  |
| Temper outbursts |  | Cannabis use |  |
| Argumentative |  | Other drug use |  |
| Violent fantasies/impulses  |  | Questions or concerns with your sexuality |  |
| Harmful to others |  | Questions or concerns with your gender or gender expression |  |
| Periods of time with very high energy levels |  | Participating in high-risk sexual activity |  |
| Talking or thinking too fast |  | Difficulty performing sexual activity |  |
| Paranoia |  | Feeling guilty about sex |  |
| Poor body image |  | Relationship problems |  |
| Overreactive |  | Overly sensitive to criticism |  |
| Fear of rejection |  | Difficulty trusting |  |

Please indicate the degree of distress you are experiencing at this time:

Mild Moderate Severe

Please describe any notable mental health or behavioral issues of family/relatives:

What else do you want me to know about you?

Client Signature: Date: