

New Day Counseling, Troy, MI 48084

LIFE HISTORY Self-Report Form

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. If you would rather not answer a question, simply leave it blank or write, “do not want to answer.” Use N/A where **not** applicable.

NAME: _____ **DATE:** _____

ADDRESS: _____ **DATE of BIRTH:** _____

CITY, STATE, ZIP: _____ **AGE:** _____

In case of emergency contact

Name: _____ Relationship: _____

Phone(home)_____ (work)_____ (other)_____

Address (street, city, state, zipcode)_____

(optional) Email: _____

Check here if interested in receiving information from New Day Counseling

Marital History

Marital Status:

Never married

Married (How long? _____ Are you satisfied with your marriage? Yes No)

Remarried (How many times? _____)

Separated

Divorced/Annulled [Date(s)_____ Reason_____]

Widowed

Co-habiting (How long?_____)

In committed relationship (How long?_____Rate you level of commitment, on scale of 1-10 where 1=low and 10=high? _____)

Living Arrangements

Family members or persons currently living with you:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Current School Grade or Occupation</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently live in: ___House ___Room ___Apartment ___Other: _____

Please list any of your children currently not living with you:

<u>Name</u>	<u>Age</u>	<u>Where Living and with Whom</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

City and State of major childhood residence: _____

Parents: Married Divorced Separated Living Together

FATHER Age: ___ or Age at Death: ___ Cause of death: _____ How old were you? ___

Ethnic background: _____ Religion: _____

Citizenship: _____ Education: _____

Occupation: _____ Health: _____

MOTHER Age: ___ or Age at Death: ___ Cause of death: _____ How old were you? ___

Ethnic background: _____ Religion: _____

Citizenship: _____ Education: _____

Occupation: _____ Health: _____

SIBLINGS: Age(s) of brother(s): _____ Age(s) of sister(s): _____

What is your birth order (oldest, youngest, middle, only child)? _____

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

If you were not brought up by your parents, who raised you? Between what years? _____

Were you adopted? Yes No *If yes*, from what age did you know? _____

Does anyone in your family suffer from a mental or emotional disorder (depression, anxiety, alcoholism, schizophrenia, etc.)? Yes No Please explain: _____

Has any one of your relatives ever attempted or committed suicide? ____ Yes ____ No

Did any of the following apply to your childhood or adolescence?

____ Happy childhood	____ Emotional problems	____ Physical abuse
____ Unhappy childhood	____ Behavioral problems	____ Sexual abuse
____ Family problems	____ School problems	____ Emotional abuse
____ Alcohol abuse	____ Legal troubles	____ Traumas
____ Drug abuse	____ Medical problems	____ Severely bullied/ or teased
____ Neglected	____ Financial problems	____ Very few friends
____ Severely punished	____ Strict religious upbringing	

Education

What is the last grade of school you completed or highest degree? _____

Are you in school now? Yes No *If yes, where?* _____ *Major?* _____

Other training: _____ Strengths: _____ Weaknesses: _____

Childhood Educational and Developmental History—please answer the following questions based on your childhood:

Birth defects or handicaps? Yes No Speech problems? Yes No

History of learning disabilities? Yes No What subject(s)? _____

Special education? Yes No What grade(s)? _____ Tutoring? _____ Explain: _____

Repeated any grades? Yes No Grade(s): _____

Behavioral Problems? Yes No

If yes: Where? ____ Home ____ School *Nature of problems* _____

Problems with peers? Yes No *Nature of problems* _____

Work History

Current Employment Status:

	<u>You</u>	<u>Spouse</u>	<u>Military Data</u>
Employed full-time	_____	_____	You:
Employed part-time	_____	_____	Active duty? _____
Laid-off	_____	_____	Branch? _____
Unemployed	_____	_____	Discharge _____
Disabled	_____	_____	
Retired	_____	_____	Spouse:
Stay-home mom or dad	_____	_____	Active duty? _____
Student	_____	_____	Branch? _____
Other _____	_____	_____	Discharge _____

What type of work do you do? _____ Spouse? _____

Are you satisfied with the type of work you do? Yes No

If no, please explain: _____

What kinds of jobs have you held in the past? _____

Do you do any volunteer work? Yes No If yes, explain: _____

Counseling History

Have you ever sought help from a counselor, psychologist, psychiatrist, or pastor?

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

Was it helpful? Yes No

Have you ever been hospitalized for emotional reasons? Yes No If yes, please explain.

Medical History

How do you rate your present physical health? _____Excellent _____Good _____Fair _____Poor

Primary Care Physician (name, address, phone number) _____

Date of last medical exam: _____

List any medical problems you are currently experiencing: _____

List any physical disabilities you have: _____

Please indicate if you have any history of the following ailments in your family:

- Tuberculosis Heart disease Diabetes Cancer Ulcers
 Glandular problems High blood pressure Other: _____

List any medications you are currently taking:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you exercise? _____Yes _____No If yes, what type?: _____

Do you eat balanced meals? _____Yes _____No If no, explain: _____

How much caffeine do you consume per day (in coffee, soft drinks, tea)? _____

Do you smoke? _____Yes _____No If yes, for how long? _____ How much? _____

Have you ever tried to quit? _____Yes _____No If yes, what method(s) did you try? _____

Have you lost or gained weight over the past 6 months? _____ How much? _____

Do you feel you are overweight or underweight? _____

Are you presently dieting? ___ Yes ___ No Explain: _____

Do you have difficulty falling asleep or staying asleep? _____

Are you experiencing any recurring nightmares or disturbances? _____

Personal Health History

How do you occupy your free time (present interests, hobbies, activities, projects)? _____

Whom/What do you consider the strongest supports in your life (God, family, friends, group memberships/involvement, hobbies, interests)? _____

Do you make friends easily? _____ Do you currently have any committed friendships? _____

Have you ever had thoughts of suicide (killing yourself)? ___ Yes ___ No

If yes, when? _____

Have you ever taken any action toward ending your life? ___ Yes ___ No

If yes, please explain: _____

Have you ever had thoughts or plans of homicide (killing someone else)? ___ Yes ___ No

If yes, please explain: _____

Please indicate which of the following emotions you have or are presently having difficulty controlling:

___ anger	___ shame	___ fear of hurting loved ones
___ anxiety/panic	___ loneliness	___ fear of losing your mind
___ depression	___ worthlessness	___ fear of dying
___ frustration	___ hopelessness	___ fear of going to hell
___ hatred	___ confusion	___ fear of abandonment
___ guilt	___ fear of committing suicide	___ fear of _____

Please list any additional problems of difficulties: _____

Legal History

Have you had any police arrests in the past? ___ Yes ___ No If yes, how many? _____

What was the nature of these arrests? _____

Have you had any court convictions in the past? ___ Yes ___ No *If yes, how many?* _____

What was the nature of these convictions? _____

Were these arrests or convictions in any way related to the use of alcohol or drugs?

___ Yes ___ No *If yes, please explain:* _____

What is your current legal status? ___ Clear ___ Parole ___ Probation ___ Other

Have you been involved with Protective Services? ___ Yes ___ No

If yes, please explain: _____

Have you been involved in any type of lawsuit (against others or against you)? Yes No

If yes, please explain: _____

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: _____

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

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

Reason(s) for use: Addicted Build confidence Socialization Taste
 Escape Self-medication Other (specify): _____

Does anyone in your family currently have a drug/alcohol problem? Yes No

If yes, please explain: _____

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

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

Do you think, now or in the past, you have a drinking/drug abuse problem? Yes No

Has anyone ever expressed concern about your drinking/drug use? Yes No

If yes, please explain: _____

Signature _____ **Date** _____