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 **n**ot **a**pplicable.

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-habitating (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:

Name	Relationship	Age	Current School Grade or Occupation

Do you currently live in: ____House ____Room ____Apartment ____Other: _____

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

Name	Age	Where Living and with Whom

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/
____Neglected	____Financial problems	or teased
____Severely punished	____Strict religious upbringing	____Very few friends

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:

	You	Spouse
Employed full-time	_____	_____
Employed part-time	_____	_____
Laid-off	_____	_____
Unemployed	_____	_____
Disabled	_____	_____
Retired	_____	_____
Stay-home mom or dad	_____	_____
Student	_____	_____
Other_____	_____	_____

Military Data
You:
Active duty?_____
Branch?_____
Discharge_____

Spouse:
Active duty?_____
Branch?_____
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:

Name of medication	Dosage	Frequency	Reason

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, ecstacy, 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**_____