INNERACTION Therapy for Inner Well-Being and Interpersonal Success

Life History Questionnaire

The purpose of this questionnaire is to quickly obtain a more comprehensive picture of your background. By completing these questions as fully and as accurately as possible, you will facilitate your therapeutic process. This questionnaire will save you both time and money. These questions are strictly confidential and no outsider is permitted to see your case record without your permission.

1. GENERAL INFORMATION

Name	Address	City/State/Zip Code
Telephone number(s) Cell	Home	
Age	Occupation	

By whom were you referred? _____

With whom are you now living? _____

Do you live in a _____House _____ Apartment _____ Hotel _____ Room _____ Other _____

Relationship status:

___Single ___Engaged ___ Married ___Re-married ___Separated ___Divorced ___ Widowed ___ Live-in

Partner's Name, Age, Occupation: _____

Religion/spirituality in your childhood_____

Religion/spirituality as an adult_____

2. CLINICAL

State the nature, history, and duration of your main problems from onset to present:

_____

_____

_____

_____

On the scale below, please estimate the severity of your problems:

_____Mildly upsetting _____ Moderately Severe _____ Very Severe

_____ Extremely Severe _____ Totally Incapacitating

Are you taking any medications? If so, please list all medications, vitamins and herbal remedies, including dosage that you are currently taking. _____

_____

_____

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3. **PERSONAL DATA**

Date of Birth Height Weight

Mother's Health during Pregnancy

_____

Check any of the following that applied during childhood:

_____ Night Terrors _____ Bedwetting _____ Sleepwalking _____ Thumb sucking
_____ Nail Biting _____ Fears _____ Stammering _____Happy Childhood
_____Unhappy Childhood Other(s) _____

Did you like school? _____ How well did you do? _____

History of learning problems? _____ Explain: _____

Health during childhood? _____ List Illnesses _____

Health during adolescence? _____ List Illnesses _____

List any surgical operations and age at the time _____

Any accidents? _____

List your five main fears:

1. _____ 2. _____

3. _____4. _____

5._____

Check any of the following that apply to you:

_____ Headaches	_____ Dizziness	_____ Fainting Spells	_____ Suicidal Ideas
_____ Anger	_____ Fatigue	_____ Bowel Disturbances	_____ Dislike Vacations
_____ Palpitations	_____ Anxiety	_____ Unable to Relax	_____ Nightmares
_____ Bad Home conditions	_____ No appetite	_____ Can't make Friends	
_____ Inferiority Feelings	_____ Feel Tense	_____ Financial Problems	
_____ Compulsive Eating	_____ Depressed	_____ Alcoholism	_____ Lonely
_____ Excessive Sweating	_____ Unable to have a good time		_____ Tremors
_____ Stomach Trouble	_____ Often use aspirin	_____ Over ambitious	_____ Take Drug
_____ Take Sedatives	_____ Can't make decisions	_____ Allergies	
_____ Memory problems	_____ Repeating Thoughts	_____ Feel Sick	
_____ Concentration difficult	_____ Don't Like Weekends	_____ Shy	_____ Sexual problems

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Please list any additional difficulties here_____

_____

_____

_____

_____

Have you ever felt like hurting yourself? _____

When and how? _____

Have you ever thought about hurting someone else? _____

Explain_____

_____

Check any of the following words which apply to you:

_____Worthless	_____ Useless	_____ A 'nobody'	_____"Life is Empty"	_____ Naive
_____ Inadequate	_____ Stupid	_____ Incompetent	_____ Guilty	_____ Evil
_____ Morally Wrong	_____ Ugly	_____ Hostile	_____ Full of Hate	_____ Anxious
_____ Can't Do Anything Right		_____ Agitated	_____ Cowardly	_____ Unloved
_____ Unassertive	_____ Depressed	_____ Misunderstood	_____ Lonely	
_____ Aggressive	_____ Confused	_____ Unattractive	_____ In Conflict	
_____ Horrible Thoughts	_____ Full of Regret	_____ Worthwhile	_____ Considerate	
_____ Sympathetic	_____ Intelligent	_____ Attractive	_____ Confident	

Other: _____

Present interests, hobbies, and activities_____

How is most of your free time occupied? _____

Were you ever bullied or severely teased? If yes, when and how? _____

Have you ever been arrested or convicted of a criminal offense? _____

If yes, describe the nature, time_____

Were you ever in the Military? _____ Date(s) of service_____

Type of Discharge_____

4. OCCUPATIONAL DATA

What sort of work are you doing now? _____

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Are you satisfied with your work? _____

What do you dislike about it? _____

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

Ambitions: Past_____Present_____

_____

5. SEX INFORMATION

Parental attitudes toward sex (for example, was there sex instruction or discussion in the home?)

When and how did you derive your first knowledge of sex?

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

Any relevant details regarding your first or subsequent sexual experience?

Is your present sex life satisfactory? _____ If not, explain _____

Are you sexually inhibited in any way? _____

Any sexual abuse history? _____Explain_____

6. MARITAL HISTORY

How long did you know your marriage partner before living together? _____

How long have you been married? _____

In what areas is there compatability? _____

Incompatibility? _____

How do you get along with your inlaws? _____

Any previous marriages? _____ How many? _____

How did these end? _____

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Any history of miscarriages, abortions, adoption or death of a child? _____

View of self as a parent? _____

7. FAMILY DATA

Father:

Living or deceased? _____ If deceased, how old were you when he died? _____

How did you feel? _____

Relationship with father – past_____

Present_____

How are you like him? _____

Mother:

Living or deceased? _____ If deceased, how old were you when she died? _____

How did you feel? _____

Relationship with mother – past_____

Present_____

How are you like her? _____

Siblings:

Number of brothers_____ Ages _____

Relationship – past _____

Present_____

Number of sisters_____ Ages _____

Relationship – past _____

Present _____

In what ways were you punished by your parents as a child? _____

_____

Did you feel loved by your parents? _____

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If you have a step-parent, give your age when parent remarried_____

Give a brief description of your relationship with the step-parent_____

_____

If you were not brought up by your parents, who did bring you up and between what years? _____

_____

Who are the most important people in your life? _____

Why? _____

Does any member of your family suffer from alcohol/drug abuse? _____ Who? _____

Any physical abuse in your family? _____

Explain_____

8. THERAPY

List the benefits you hope to derive from therapy

What do you think therapy is all about? _____

Past experience with therapy_____

How long do you feel your therapy should last? _____

Past/current medications for emotional problems_____

Past psychiatric hospitalization? _____When? _____

For how long? _____ Describe benefits_____

9. DRUGS AND ALCOHOL

How much alcohol do you consume daily? _____

How long have you used alcohol? _____

Has anyone ever told you that your drinking is a problem? _____ Who? _____

When feeling troubled or under pressure, do you drink more heavily than usual? _____

Do you sometimes feel a little guilty about your drinking? _____

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Are you irritated when you family or friends discuss your drinking? _____

Have you ever had a memory "blackout"? _____ Frequency? _____

What is your experience with drugs? _____

How often do you use drugs? _____

What kind of drugs do you use? _____

How long have you used drugs? _____

Have you ever attended a drug or alcohol program? _____ When? _____

How long were you involved in this program? _____

How long have you been "clean and sober"? _____

How much of the following have you been using per day?

Coffee/other caffeine _____Cigarettes (packs) _____

Do you have any other habits/behaviors that you feel are "out of control"? (Such as eating, gambling, spending, lying, sex, etc.) _____

_____

10. **SELF-DESCRIPTION:** (Please complete the following with the first thing that comes to mind) Do these quickly and without a lot of thought.

I am a person who _____

One of the things I feel proud of is _____

It's hard for me to admit _____

One of the things I can't forgive is _____

One of the things I feel guilty about is _____

One of the ways people hurt me is _____

The one thing I am angry about is_____

What I needed from my mother and didn't get was _____

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What I needed from my father and didn't get was _____

My greatest strengths are_____

11. BEHAVIOR:

What is there about your present behavior that you would like to change? _____

Describe any fearful or distressing event not previously mentioned_____

Have you ever lost control (i.e., temper or crying or aggression)? _____

Describe what happened_____

Is there any other information that may aid your therapist in understanding and helping you?

When therapy is finished, how do you expect yourself to be different? _____

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