

Life History

Name _____ Date _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Relationship to Client _____

Is this the first time you've been to a counselor? **Yes / No**

If no, when did you receive counseling? Age(s) _____

Reason(s) _____ Did counseling help? **Yes / No**

If no, explain why _____

Who raised you? (check all that apply)

- Both parents together – from age: _____ - _____
- Both parents – shared custody – separate households- from age: _____
- One parent only – from age: _____
- One parent & one step-parent
- Grandparents
- Aunt/uncle other relative
- Other – describe: _____
- Adopted – at age: _____ was told at age: _____

Parents:

Mother: age ____ Is she still alive? **Yes / No** – If no, her age at death: ____ & your age when she died: ____ Cause of death: _____

Mother's occupation: _____ retired? **Yes / No**

If alive, Mother's health: **good fair poor**

Explain: _____

Father: age ____ Is he still alive? **Yes / No** – If no, his age at death: ____ & your age when he died: ____ Cause of death: _____

Father's occupation: _____ retired? **Yes / No**

If alive, Father's health: **good fair poor**

Explain: _____

Siblings: (list how many of each and their ages)

Brothers _____ Sisters _____

Step/Half-brothers _____ Step/Half-sisters _____

Children: (list how many you have and their ages)

Sons _____ Daughters _____

Stepsons _____ Stepdaughters _____

Do any of your children or step-children have significant health or educational challenges? **Yes / No** If yes, briefly explain: _____

Are any of your family relationships part of the reason for coming to counseling today? **Yes / No**

If yes, briefly explain: _____

Relationship status:

Are you (check all that apply)

- Married – if yes, when were you married? _____
- Separated – if yes, for how long? _____
- Divorced – if yes, when were you divorced? _____
- Living with partner – if yes, for how long? _____
- In committed relationship – if yes, for how long? _____
- Other – describe _____

Is this relationship part of the reason for coming to counseling today? **Yes / No**

If yes, briefly explain: _____

Have you ever considered killing yourself? **Yes / No**

Have you ever taken action toward killing yourself? **Yes / No** – If yes, please describe: _____

Are you currently considering killing yourself? **Yes / No**

Have you ever considered killing someone else? **Yes / No**

Have you ever taken action toward killing someone else? **Yes / No** – If yes, please describe: _____

Are you currently considering killing someone else (that is, do you have a plan)? **Yes / No**

Education & Career:

Please check all that you have completed -

- GED
- High school diploma
- Associates degree in _____
- Bachelor's degree in _____
- Master's degree in _____
- Doctorate degree in _____
- Other certificate or specialized training _____

Are you currently employed? **Yes / No** – If yes, job title _____

Are you satisfied with your job? **Yes / No**

Is your spouse/partner employed? **Yes / No** – If yes, job title _____

Is he/she satisfied with his/her job? **Yes / No**

Substance Use

While this is not a substance abuse treatment facility, it is often helpful to know clients' substance use history. This is strictly confidential and is meant to help your counselor have a more thorough understanding of you and your lifestyle.

Current substance use (check all that apply):

- Alcohol – frequency _____ last use _____
- Marijuana – frequency _____ last use _____
- Cocaine – frequency _____ last use _____
- Tranquilizers – frequency _____ last use _____
- Pain pills – frequency _____ last use _____
- Other – describe _____ frequency _____
last use _____
- Other – describe _____ frequency _____
last use _____

Have any of your family, friends or co-workers told you they think you have a problem with substance use/abuse? **Yes / No**

Do you think you have a problem with substance use/abuse? **Yes / No**

Does anyone in your immediate family (parents or siblings) have a substance abuse problem? **Yes / No** – If yes, who? _____

Medical:

How would you describe your current health? (circle one)

Excellent Good Fair Poor

Explain: _____

Medications:

Rx Name	Taken for	Dose

By signing below, I attest that the information given on this form is valid and accurate to the best of my knowledge. I understand that this information is confidential and is meant to help my counselor provide the best care possible.

Client Signature Date