www.livingwellcc.com

LIFE HISTORY FORM **First appointment date: ____/_____/______**
Please only use a pen when completing this form. **First appointment time: ____:____A.M./P.M**
This form must be returned at least one week prior to your counseling appointment.
PLEASE READ THROUGH THIS ENTIRE FORM BEFORE FILLING IT OUT. THANK YOU.

For Office Use Only	Date Received: ____________ Notes:

PURPOSE The purpose of this life history is to obtain a comprehensive picture of your background. Please complete the form as fully and accurately as you can by yourself. If the completed life history is received before your actual appointment and reviewed by your counselor, you will facilitate the interview process and counseling time. Your counselor will keep this record strictly confidential, and the information is not available to anyone without **your written permission**.
(*A child or client who cannot read and write may be asked the questions by an adult and the person's answers written for them. **Information unknown to the child may be entered by an adult**.)

TODAY'S DATE: _____/_____/______ **By what name would you like to be called?**_____________________

NAME____ **PHONE (home): (_____)______/________________**

First Middle Last **PHONE (work): (_____)______/________________**

May we call you at work? ❑ Yes ❑ No Cell phone:_______________________________

FAX: (_____)______/_________________

MAILING ADDRESS ________________________________**E-MAIL**: ____________________________________

CITY___________________________**STATE/PROV.**___________ **ZIP/POSTAL CODE** _____________

AGE:_______**BIRTH DATE**:___/____/______

Emergency contact person ______________________**PHONE (home): (_____)______/___________**

RELATIONSHIP____ **PHONE (work): (_____)______/___________**

STREET ADDRESS _______________________________**Apt:**_________

CITY ______________________**STATE/PROV** _____________________ **COUNTRY**______________________**ZIP/POSTAL CODE**___________________

Are you or were you in military service ❑ Yes ❑ No If yes, which branch of the military? _______________________
Religion/Denomination: ___________________________ Place of Worship: ____
Worship Attendance (check one): ❑ Regular ❑ Occasional ❑ Not at All
I learned about or was referred to Living Well Counseling & Consulting by ____
How strongly do you want help for your problem? (check one) ❑ Very much ❑ Moderately ❑ Could do without
I have talked about my problem with:

	Psychiatrist MD	Psychologist Ph.D	Other Professional	Lay Cnslrs	Pastoral
Type of Cnsling					
# of Hours					

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NEED FOR COUNSELING

State in your own words the nature of your concern. What is it that you need? What do you want?

If your problem is cyclical or has a pattern to it, state approximately how often it occurs and how long it lasts.

If you have had previous counseling for this problem, state with whom and describe the outcome.

Have you ever been diagnosed with a mental illness or disorder? If so, please explain.

Has it ever been **suggested** you be tested for: . Bi-Polar . Borderline Personality Disorder
. Dissociation/DID . Depression . Schizophrenia . Other:________________________

BEGINNINGS

Place a check mark in front of all that apply to you, or write the facts as they pertain to each item.
Place of Birth: ____________________ Weight at Birth: _______pounds ______ounces

I was born: ❒ on time ❒ late: How late? ____________ ❒ premature: How premature? ____________

❒ delivered Caesarean Section

❒ I was a wanted baby. How do you know?

❒ I was adopted ___________❒ days ❒ weeks ❒ months ❒ years after being born.

❒ Birth mother and natural father were **married to each other** before my conception

❒ Birth mother and natural father were **not happily married** during my time in the womb

❒ Natural father was gone much of the time while I was in the womb

❒ Medications or forceps had to be used for my delivery (difficult labor/delivery?)

❒ Birth mother and /or natural father were grieving the loss or potential loss of a loved one during my womb life

❒ Birth mother experienced **a previous miscarriage or abortion** before I was conceived

❒ Birth mother had a difficult **previous pregnancy**

❒ Birth mother had a difficult pregnancy **with me**. What made it difficult?

❒ Birth mother and natural father were struggling with difficulties of life while I was in the womb. If yes, what were they:

What is the story your family tells about your coming into the world?

What events in your early childhood were significant to you?

List the number of "times you moved" in your first 18 years of life.

Age:	From:	To:	Reason:

FAMILY DATA

Please be prepared to complete a genogram as one of your assignments during your time at Living Well CC. A genogram is a family tree, consisting of the names of your parents and your parents' parents, their experiences, key events, problems, religious practices, stories, etc.

List all of your brothers and sisters from oldest to youngest, **including yourself**. Please list in birth order, including any miscarriages, or abortions you know about.

Name	Sex	Age	Marital Status	Job	Brief Description
	M/F				
	M/F				
	M/F				
	M/F				

Describe your relationship to your brothers and sisters in childhood.

Describe the relationship to your brothers and sisters presently.

Who played together and why?

Have you ever lived with anyone other than your parents? ❑ Yes ❑ No

If yes, how old were you? ______ How long? __________

With whom did you live? ______________________ Why?

How would you describe the atmosphere of your childhood home?

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc? If yes, why?

Were you ever bullied or given a nickname? If yes, by whom and why?

Do you make friends easily? Do you keep them?

List any fearful or distressing experiences not previously mentioned:

EDUCATIONAL HISTORY

School/College/University	Major/Degree	Date Received:

EMPLOYMENT HISTORY (List from most recent to earliest)

Job	Type of work	Age	Left Because:
1st			
2nd			
3rd			
4th			
5th			
6th			
7th			

Are you satisfied with your current income level? ❒ Yes ❒ No

Do you enjoy your present job? ❒ Yes ❒ No If No, why?

What are your ambitions and aspirations?

SEX INFORMATION

What was the attitude towards sex in the home in which you grew up? How was it discussed or instructed?

At what age did you derive your knowledge of sex? ________ How did you learn?

When did you become aware of your sexual impulses? What happened?

Did you ever have any anxieties, guilt feelings or trauma arising out of:

- Masturbation? If yes, please explain:

- Sexual experience with the **opposite sex**? If yes, please explain:

- Sexual Experience with the **same sex** (homosexuality)? If yes, please explain:

Did anyone ever touch you inappropriately in a sexual way? If yes, please explain:

Are there any questions and/or concerns you have about sex, sexual experiences and/or sexual identity, past/present or future?

DESCRIBE YOUR PARENTS

Answers on this page describe the mother and father who took primary responsibility for rearing you. If either person is other than your biological (birth) parent, **please copy this page**, complete it for your biological parent/s and attach that page to the back of this life history

FATHER's Name: Current age:	**MOTHER's** Name: Current age:
Occupation before retiring:	
If deceased, what was the cause of death and their age? What was your age?	
His Personality	**Her Personality**
His Values	**Her Values**
Kind of home environment he provided	**Kind of home environment she provided**
Describe you Father's relationship with Mother?	**Describe your Mother's relationship with Father?**

Who was in charge? Who was the real head of the house?

Describe his relationship with the children?	**Describe her relationship with the children?**
How did he show love?	**How did she show love?**
What was his ambition for the children?	**What was her ambition for the children?**
Describe your ability to confide in him	**Describe your ability to confide in her**

(Continued) FATHER	MOTHER
Form of punishment he used	**Form of punishment she used**
As a child, what I liked about him	**As a child, what I liked about her**
As a child, what I disliked about him	**As a child, what I disliked about her**
Who was Dad's favorite child? Why?	**Who was Mom's favorite child? Why?**
Which child was most like him? Why?	**Which child was most like her? Why?**
Which child was most different from him? Why?	**Which child was most different from her? Why?**
Describe any problems with addictions and/or immorality	**Describe any problems with addictions and/ or immorality**
What is your Father's ethnic heritage?	**What is your Mother's ethnic heritage?**

MARITAL INFORMATION

	Name of Spouse	Length of Engagement	Age when Married		Length of Marriage	Reason Why It Ended	# of Children from that Marriage
			You	Spouse			
1st Marriage							
2nd Marriage							
3rd Marriage							
4th Marriage							

PRESENT MARRIAGE Anniversary Date: ___________________

What I liked the first few years:

What my spouse liked the first few years:

What I disliked the first few years:

What my spouse disliked the first few years:

What I have liked/disliked in the last few months:

What my spouse has liked/disliked in the last few months:

Place the letter "C" or "I" in each blank below as it applies to your present marriage.
C = Most Compatible I = Incompatible

________ Value system _______ Commitment to God ______ Devotion to spouse _____ Devotion to children
________ Intellect _______ Sleep requirements ______ Financial planning _____ Child discipline
________ Energy level _______ Food appetite ______ Spending money _____ Devotion to work
________ Social time _______ Exercise needs ______ Parenting style _____ Household duties
________ Planning _______ Sexual needs ______ Recreational interests _____ In-law relationships
________ Goals _______ Need for touch ______ Educational preparation _____ Hobbies
________ Neatness _______ Need for time alone ______ Sensitivity to feelings _____ Other __________
________ Friends _______ Conversation ______ Spiritual growth _____ Other __________

(Present Marriage, continued)
Give three specific examples of things you would like to see your spouse **do more often** (particular things that mean something to you)

Give three specific examples of things you would like to see your spouse **stop doing** (three particular things that irritate you.):

List the names of your children, from oldest to youngest. State if any of these children are from previous marriages, or adopted. **Also, in order of birth include any miscarriages or abortions**.

Name	Sex	Age	Marital Status	Job	Brief Description
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				

PREVIOUS MARRIAGE
What I liked about him/her:

What I disliked about him/her:

What my previous spouse liked about me:

What my previous spouse disliked about me:

What ended the relationship?

PERSONAL AND FAMILY HEALTH Please place a check mark (✓) beside each listed item as it applies to you: S = self or your family: F = family.

S	F		S	F		S	F		S	F		S	F	
		inadequate			jaundice			alcoholism			guilt feelings			blood pressure problems
		anemia			abortions			smoker			miscarriages			P.M.S.
		allergies			asthma			shyness			fear of knives			suicidal thoughts
		lonely			flee worship			fantasy			wish born another time			blasphemous thoughts
		perfectionist			fear failure			drug abuse			Thumb-sucking			suicide
		generous			ambitious			gambling			DES baby			feel ripped off
		dependent			pleaser			obsessive			dislike confrontation			financial problems
		unworthy			diarrhea			unable to relax			difficulty deciding			rheumatic fever
		constipation			underweight			anorexia			peacemaker			excessive exercise
		bulimia			secretive			compulsive			angry			arrested for crime
		obesity			body image worry			cravings			insecurity			lustful thoughts
		controlling			moody			sexual addiction			pornography			hepatitis [A][B]
		bedwetting			masturbation			venereal disease			bladder infections			bowel disturbances
		stammering			nail biting			panic attacks			flashbacks			sleepwalking
		forgetful			intelligent			gifted [arts]			dizziness			unexplained muscle pain
		headaches			double vision			TMJ			blurred vision			accused of lying
		insomnia			suggestible			homosexuality			strange sensations			fibromyalgia
		voice changes			daydream			hear voices			convulsions			uneven achievement in school
		blood diseases			hearing problems			time conscious			shaking/tremors			thyroid problems
		doubts			lost interest			worry			scars			orthopedic problems
		sinus problems			autism			grief			cancer			breathing problems
		depression			fatigue			heart disease			kidney problems			liver problems
		feel tense			stomach trouble			feel panic			paralysis			fear going to hell
		cold sores			nightmares			sexual problems			sees God as distant			poor work performance
		difficult to pray			High energy			frustration			bad home conditions			sees God as harsh
		low energy			easily annoyed			fear success			martyr			difficult to read Bible
		fear God			feel inferior			difficulty deciding			spiritual abuse			unable to hold boundaries
		verbal abuse			emotional abuse			mental retardation			fear travel			bad reaction to anesthetics
		arthritis			bitter			bullied as child			lack common sense			hard to tell right from wrong
		feel invisible			physical abuse			skin diseases			narcolepsy			difficulty deciding what to wear
		diabetes			brain injury			see life as good			can't express feelings			fear losing mind
		infertility			learning disability			see life as bad			flooded by feelings			fear will hurt others
		mental illness			dread weekends			not listened to			unhappy childhood			fear terminal illness
		dread vacations			dread holidays			happy childhood			tuberculosis			see moving shadows

SPIRITUAL EXPERIENCES

Please place a check mark beside each item in which you or your family members have participated. Key: S = self F = family

S	F		S	F		S	F	
		Islam			Masons (Freemasonry)			Astral-projection
		Wicca			Christian Science			Astrology
		Bahai			Children of God			Automatic writing
		EST			Church of the Living Word			Black/white magic
		Eckankar			Cult of Diana			Blood pacts
		Father Divine			Herbert W. Armstrong			Clairvoyance
		Hare Krishna			(Radio Church of God)			Dowsing (water-witching)
		Hinduism			Jehovah's Witness			Fetishism
		Science of Creative Intelligence			Scientology			Fortune telling
		Rosicrucian			Mormonism			Ghosts
		Roy Masters			New Age			Healing magnetism
		Science of the Mind			Swedenborgianism			Hypnosis
		Silva Mind Control			The "Local Church" **(the cult)**			Incubi/succubae (sex spirits)
		Theosophical Society			The Way International			Magic charming
		Transcendental Meditation			Unification Church			Materialization
		Yoga			Unitarianism			Mental suggestion
		Buddhism			Unity			Ouija board
		Satanism			Witchcraft			Palm reading
		Other: ____________________			Other: ____________________			Pendulum &rod
		Other: ____________________			Other: ____________________			Spells
								Reading tea leaves, etc.
								Séance
								Tarot cards
								Telekinesis (i.e., table lifting)
								Telepathy
								Trance speaking
								Visionary dreams
								Drugs

How have any of the items you checked affected your life?

SELF-DESCRIPTION

In what situations do you **lose** self-control?

In what situations do you **maintain** self-control?

How do you believe you would be described by: (this is not their description, but how **you** believe they would describe you)

- Your spouse:
- Your best friend:
- Your worst enemy (even if you don't really have one):
- Yourself:

PLEASE COMPLETE THE FOLLOWING SENTENCES

1) As a child, I . . .

2) My brothers and/or sisters . . .

3) For me, school was . . .

4) My childhood fears were . . .

5) My childhood ambitions were . . .

6) My role in the family . . .

7) My role in my group of friends was . . .

8) The significant events in my physical and sexual development were . . .

9) The significant events in my social development were . . .

10) The most important values in my family were . . .

11) What stands out the most for me about my family life is . . .

12) My parents' relationship to each other was . . .

Nutritional History:

Do you consume the following foods on a daily basis? (Please check each box that applies)

- ❒ Deli meats
- ❒ Processed foods
- ❒ Fresh vegetables – Please indicate which vegetables____
- ❒ Fresh Fruit - Please indicate which fruits____
- ❒ Candy – how often? ____
- ❒ Cheese
- ❒ Soda pop - _____ diet _______ regular
- ❒ Energy drinks
- ❒ Coffee
- ❒ Whole grains
- ❒ White flour and/or white flour products
- ❒ Alcohol
- ❒ Margarine
- ❒ Organic foods – what percentage of your daily diet is organic? __________%
- ❒ Sugar – what percentage of your daily diet consists of sugary products? ________%
- ❒ Bottled water
- ❒ Tap Water
- ❒ Eggs
- ❒ Fast food – what percentage of your daily diet is fast food? ________%
- ❒ Beef
- ❒ Poultry
- ❒ Fish
- ❒ Over the counter pain medications: please indicate____
- ❒ Wheat products: please indicate ____
- ❒ Corn products: please indicate____
- ❒ Daily vitamins: please list____
- ❒ Nutritional supplements: please list____
- ❒ What are your main physical complaints ?

____

____

____

HEALTH INFORMATION AND MEDICAL HISTORY

Your present height: _____________ weight: _________

Please indicate any medications you are presently taking, dosage and treatment goal:

Medication	Dosage	Condition being treated

Please indicate any past injuries, date of injury and treatment prescribed:

____

____

____

____

____

____

____

Please indicate any surgery you may have had and the approximate date:

____

____

____

____

____

____

____

____

Please indicate any allergies you are experiencing:

____

____

____

How do any of these health-related issues relate to why you are coming to see us today?

When was the last time you felt well, both physically and emotionally, for a fair amount of time and why?