



**Life History Questionnaire**  
**(All files are held in strict confidence)**

Student ID _____		Date _____		Counselor _____	
First Name _____		MI _____	Last Name _____		Maiden _____
Age _____	Date Of Birth _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Ethnicity</b> <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> International Student Country: _____		<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black		<b>Relationship Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Campus PO Box _____					
Local Address _____		City _____		State _____	Zip _____
Local Phone _____		<input type="checkbox"/> May We Leave A Message?	Email Address _____		<input type="checkbox"/> May We Send A Message?
Permanent Address _____		City _____		State _____	Zip _____
Permanent Phone _____		<input type="checkbox"/> May We Leave A Message?			
I am currently in my _____ <sup>1<sup>st</sup></sup> _____ <sup>2<sup>nd</sup></sup> _____ <sup>3<sup>rd</sup></sup> _____ <sup>4<sup>th</sup></sup> _____ <sup>5<sup>th</sup></sup> _____ <sup>6<sup>th</sup></sup> + yr of college			Academic Status <input type="checkbox"/> Fr <input type="checkbox"/> So <input type="checkbox"/> Jr <input type="checkbox"/> Sr		Advisor _____
Major 1 _____		Major 2 _____		Cumulative GPA _____	
Minor 1 _____		Minor 2 _____		Number of Credits This Semester _____	
<input type="checkbox"/> Please mark this box if you are currently on academic probation			Hours per week you work in paid employment _____		
<input type="checkbox"/> Please mark this box if you have ever been on academic probation in the past					
<b>Please indicate who referred you to the Counseling Center</b>					<b>Referral Name</b> _____
Referral Type <input type="checkbox"/> Self <input type="checkbox"/> Faculty <input type="checkbox"/> Residence Life Staff <input type="checkbox"/> Other Staff		<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Other			
<b>Please read the following questions and mark those to which you would respond "yes."</b>					
<input type="checkbox"/> Have you previously been involved in counseling?		<input type="checkbox"/> Have you ever been hospitalized for mental health reasons?			
<input type="checkbox"/> Do you currently use alcohol or other non-prescription drugs?		<input type="checkbox"/> Is there a history of alcohol or drug problems in your family?			
<input type="checkbox"/> Is there a history of mental health problems in your family?		<input type="checkbox"/> Have you ever been in legal trouble?			
<input type="checkbox"/> Have you ever been physically abused?		<input type="checkbox"/> Have you ever been sexually abused or assaulted?			
<input type="checkbox"/> Have you ever been emotionally abused?		<input type="checkbox"/> Are you currently taking any prescription medications?			
<input type="checkbox"/> Are your concerns interfering with your academic performance?		<input type="checkbox"/> Are your concerns interfering with your ability to stay in school?			
<input type="checkbox"/> Have you ever attempted suicide?					
Please describe the concerns that you would like to discuss with a counselor:  _____					
How long has this problem persisted? _____			Under what condition do your problems get worse? better? _____		
Counselor Notes _____					



**Please use the following scale to answer the next three questions:**

	1	2	3	4
	Not at all	Mildly	Moderately	Highly
1. How serious do you consider your present concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How motivated are you to resolve your concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How optimistic are you that your concern(s) can be resolved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family History**

Mother's Age \_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_  
 Father's Age \_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_  
 If your parents are separated, how old were you then? \_\_\_\_\_  
 Number of brother(s) \_\_\_\_\_ What are their ages? \_\_\_\_\_  
 Number of sister(s) \_\_\_\_\_ What are their ages? \_\_\_\_\_

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:

Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

**Briefly describe your past and current relationships with your:**

Mother

Father

Stepmother

Stepfather

**Religious Affiliation**

- |   |   |
|---|---|
| <input type="checkbox"/> Jewish           | <input type="checkbox"/> None, but I believe in God |
| <input type="checkbox"/> Catholic         | <input type="checkbox"/> Atheist or agnostic        |
| <input type="checkbox"/> Protestant _____ | <input type="checkbox"/> Other _____                |

Do you desire to have your religious beliefs and values incorporated into the counseling process?

- Yes       No       Not Sure

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:



Please mark all of the following that apply

**Feelings**

- Helpless
  - Depressed
  - Shameful
  - Angry
  - Guilty
  - Hopeless
  - Lonely
  - Sad
  - Stressed
  - Unhappy
  - Other \_\_\_\_\_
- Anxious
  - Out of Control
  - Afraid
  - Numb
  - Relaxed
  - Happy
  - Excited
  - Hopeful
  - Inferiority Feeling
  - Mood Shifts

**Thoughts**

- Confused
  - Unintelligent
  - Worthless
  - Unmotivated
  - Unattractive
  - Unlovable
  - Confident
  - Worthwhile
  - Homicidal
  - Other \_\_\_\_\_
- Racing
  - Obsessive
  - Distracted
  - Disorganized
  - Paranoid
  - Suicidal
  - Sensitive
  - Honest

**Symptoms/Behaviors**

- Eating Less
- Procrastinating
- Attempting Suicide
- Poor Concentration
- Crying
- Withdrawing Socially
- Skipping Classes
- Binge Drinking
- Injuring self
- Compulsivity
- Career/Major Choice
- Acting Out Sexually
- Acting Aggressively
- Disorganization
- Impulsivity
- Recklessness
- Irritability
- Passivity
- Drug Use
- Alcohol Use
- Being Good to Yourself
- Sexual Problems
- Socializing
- Marital Relationships
- Parent/Child Conflicts
- Lack of Ambition/Goals
- Poor Peer Relationships
- Night Mares
- Worries About Body Image
- Spiritual Problems
- Dating Concerns
- Finances
- Other \_\_\_\_\_

**Physical Symptoms**

- Insomnia
- Tired
- Weight Gain or Loss
- Pain
- Headaches
- Tightness In Chest
- Dizziness or Light-headedness
- Numbness or Tingling
- Vomiting
- Rapid Heart Beat
- Dry Mouth
- Excessive Sleep
- Loss of Memory
- Eating Problems
- Other \_\_\_\_\_

Please describe any medical conditions you have:

Anything else you would like us to know about you: