Multimodal Life-History Questionnaire

*Please complete this Questionnaire as it saves*

*counselling time and enhances the entire process.*

Name:

Date:

**Purpose of This Questionnaire:**

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary, since they permit a more thorough dealing with one’s problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time. It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. **NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR PERMISSION.**

If you do not desire to answer any questions, merely write “Do Not Care to Answer.”

|  |  |
| --- | --- |
| **Date:** |  |

**Age:**

**Gender: Male**       **Female**       **(Check the appropriate box)**

**Chief Complaint/Reason for Coming for Counseling:**

**PLEASE LIST ANY RELEVANT FAMILY MEDICAL/PSYCHIATRIC HISTORY:**

**MEDICAL HISTORY/NUTRITION/ALLERGIES/PAIN:**

**Mark**  True or False

      -- I rarely use over the counter medications and/or supplements.

      -- There is no medication or medical treatment that pertains to the current chief complaint.

Choose a word or number and fill in the blank space using words in **BOLD FACE** to describe yourself.

My nutrition is **(poor, average, good)**       and generally consists of **(1, 2 or 3)**       meals/snacks per day. I pay **(little, average, close)**       attention to food groups and dietary recommendations, caffeine use is **(low, average high)**      **,** and sugar use is **(low, average high)**      **.** I pay **(little, average, close)**       attention to water intake, which amounts to approximately       ounces per day. My experience of pain in my current situation is (     /10).

**ACTIVITIES/INTERESTS/TIME-STRUCTURING:** My typical day consists of rising around       and going to      . After returning home for the day, I typically      . Weekends/days off generally are spent      . Recreational and leisure activities are, for the most part **(normal, not normal)**       for me. Overall, my lifestyle is (**normal, not normal, changed vastly**       in the past few months).

**EDUCATION/CAREER/LEARNING NEEDS:** (Check what applies)

I have completed**: Secondary SCHOOL**  **Some COLLEGE**  **COLLEGE MASTERS**   **DOCTORATE**

and experienced **SOME LITTLE** **NO**   difficulty with schoolwork.

I have generally worked in the       field. I currently work at      .

Work has been reasonably satisfying: **(YES, NO, SOMETIMES)**

Making and managing money has been: (**EASY, HARD, VERY DIFFICULT)**

Current financial condition is: **(VERY POOR, FAIR GOOD, REAL GOOD)**

**LEGAL HISTORY/BEHAVIORAL PROBLEMS/SUBSTANCE ABUSE/LIABILITIES:** There are no significant liabilities likely to deter me from resolving my presenting difficulties. **(Yes No)**

**If yes, what?**      .

**If so please explain**      .

**List any clear obstacles to your recovery (if any):**      .

**If you have a legal history or criminal back history please list below:**      .

**Substance abuse history (if applicable):**      .

If you smoke, how much do you smoke?      .

Do you consider yourself overweight? Should weight management be a part of your therapy?

YES       NO

**Faith/Important Beliefs/CULTURE/ASSETS:** Assets likely to benefit my resolution of my presenting difficulties include (**physical health, maturity, faith, exercise, prior successes in life** and       ). Cultural/socioeconomic background was **(low, average, high) .**

**FAMILY HISTORY/INTEPERSONAL FUNCTIONING/SOCIAL SUPPORTS:**

I grew up in a **SINGLE, BLENDED, or NUCLEAR** (original mom & dad) family headed by my      .

The atmosphere in my home where I was raised was:      .

Caregivers (those who raised me) were generally:      .

Abuse/neglect **(WAS; WAS NOT)** a part of the my developmental history. If yes, it consisted of:

     .

There was undesired sexual contact around the age of      , and I have experienced       as a result of that activity.

During childhood I:      .

During adolescence I:      .

By adulthood I:      .

Currently I have a **(NO LIMITED LARGE)** social support system that includes      .

If married, marital satisfaction was rated as      /10.

Sexual life is (**NON EXISTENT, POOR, AVERAGE, GOOD**)

**Sleep/Neurovegative Signs of Depression**:

I typically sleep about       hours per night. There are (**NO SOME)**       problems with getting to sleep, maintaining sleep, or early awakening, with the result that I typically awaken feeling (**VERY TIRED, TIRED SOMEWHAT RESTED, RESTED)**      .

I tend to have (**LOW MEDIUM HIGH)** energy, (**LIMITED HIGH** concentration and attention to daily activity, **LOW AVERAGE HIGH**       appetite, and **LOW AVERAGE HIGH)**       interest in sex or other formerly pleasurable activities. This overview as presented is (**NORMAL NOT NORMAL)**       over the past few weeks/months.

**1. General Information:**

|  |  |  |
| --- | --- | --- |
| **Name:** |  | **Home Phone**: |
| **Address:** |  | **Cell Phone**: |
| **City:** |  | **Email**: |
| **State:** |  | **Zip**: |
| **Occupation:** |  |  |
| **Referred by:** |  |  |
| **Age:** |  |  |
| **Gender:** |  |  |
| **Marital Status:** |  |  |
| **Remarried?** | **How many times**? | **Living with someone**? |
| **Current Type of Residence:** |  | **Birth Date:** |

**2. Description of Presenting Problems:**

State in your own words the nature of your main problems.

|  |
| --- |
|  |

On the scale below please estimate and check off the severity of your problem(s):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mildly  Upsetting | Moderately Upsetting | Very Severe | Extremely Severe | Totally Incapacitating |
|  |  |  |  |  |

When did your problems begin (give dates):

|  |
| --- |
|  |

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of your problems:

|  |
| --- |
|  |

What solutions to your problems have been most helpful?

|  |
| --- |
|  |

Have you been in therapy before or received any prior professional assistance for your problems? If so, please give name(s), professional title(s), dates of treatments and results:

|  |
| --- |
|  |

1. **Personal and Social History:**

|  |  |  |
| --- | --- | --- |
| **Place of Birth:** |  | |
| **Date of Birth:** |  | |
| **Siblings:** | Number of Brothers: | Brothers’ ages: |
|  | Number of Sisters: | Sisters’ ages: |

|  |  |  |
| --- | --- | --- |
| **Father** | Living? | Present Age: |
|  | Occupation: | Present Health: |
|  | Deceased? | Cause of Death: |
|  | How old were you at the time? |  |

|  |  |  |
| --- | --- | --- |
| **Mother** | Living? | Present Age: |
|  | Occupation: | Present Health: |
|  | Deceased? | Cause of Death: |
|  | How old were you at the time? |  |

|  |  |  |
| --- | --- | --- |
| **Religion:** | As a child: | As an adult: |
| **Education:** | Last grade completed? | Degree: |
|  | Scholastic Strengths and Weaknesses: | Degree: |

**Check any of the following that applied during your childhood/adolescence:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Happy Childhood |  | School Problems |  | Medical Problems |  |
| Unhappy Childhood |  | Family Problems |  | Alcohol Abuse |  |
| Strong Religious Convictions |  | Emotional/Behavior Problems |  | Legal Trouble |  |
| Drug Abuse |  | Other |  | Other |  |

|  |  |
| --- | --- |
| What sort of work are you doing now? |  |
| What kinds of jobs have you held in the past? |  |
| Does your present work satisfy you? |  |
| If not, please explain why: |  |
| What is your annual family income? |  |
| How much does it cost you to live? |  |
| What were your past ambitions? |  |
| What are your current ambitions? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your height? |  | | |
| What is your weight? |  | | |
| Have you ever been hospitalized for psychological problems? | | |  |
| If yes, when and where? | |  | |
| Do you have a family physician? | |  | |
| If yes, please give his/her name(s) and telephone number(s) | | Office Phone:  Cell Phone:  Email: | |
| Have you ever attempted suicide? | |  | |
| Does any member of your family suffer from alcoholism, epilepsy, depression or anything else that might be considered a “mental disorder”? | | List Family Member/s**:** | |
|  | |  | |
|  | |  | |
|  | |  | |

Has any relative attempted or committed suicide?

Has any relative had serious problems with the “law”?

# **MODALITY ANALYSIS OF CURRENT PROBLEMS**

The following section is designed to help you describe your current problems in greater detail and to identify problems, which might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven (7) modalities of *Behavior, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships and Biological Factors*.

**4. Behavior:**

**Boldface or circle** any of the following behaviors that apply to you:

Loss of control

Overeating Suicidal attempts Can’t keep a job

Take drugs Compulsions Insomnia

Vomiting Smoke Take too many risks

Odd behavior Withdrawal Lazy

Drink too much Nervous tics Eating problems

Work too hard Concentration difficulties Aggressive behavior

Procrastination Sleep disturbance Crying

Impulsive reactions Phobic avoidance Outbursts of temper

Are there any specific behaviors, actions or habits that you would like to change? Yes       No

If so, what are they?

What are some special talents or skills that you feel proud of?

What would you like to do more of?

What would you like to do less of?

What would you like to start doing?

What would you like to stop doing?

How is your free time spent?

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities? Yes No       If so, what do you do?

Do you practice relaxation or meditation regularly? Yes       No

If so, please describe

**5. Feelings:**

**boldface or circle** any of the following feelings that often apply to you:

Angry Guilty Unhappy

Annoyed Happy Bored

Sad Conflicted Restless

Depressed Regretful Lonely

Anxious Hopeless Contented

Fearful Hopeful Excited

Panicky Helpless Optimistic

Energetic Relaxed Tense

Envious Jealous Others:

List your five main fears:

1.

2.

3.

4.

5.

What feelings would you most like to experience more often?      .

What feelings would you like to experience less often?      .

What are some positive feelings you have experienced recently?      .

When are you most likely to lose control of your feelings?      .

Describe any situations that make you fell calm or relaxed:

.

**Please complete the following**:

If I told you what I’m feeling now      .

One of the things I feel proud of is

One of the things I feel guilty about is

I am happiest when

One of the things that saddens me the most is

If I weren’t afraid to be myself, I might

I get so angry when

If I get angry with you

What kind of hobbies or leisure activities do you enjoy or find relaxing?

Do you have trouble relaxing and enjoying weekends and vacations? Yes       No

If yes, please explain:      .

**6. Physical Sensations:**

**BOLDFACE** any of the following that often apply to you:

Headaches Stomach trouble Skin problems

Dizziness Tics Dry mouth

Palpitations Fatigue Burning or itchy skin

Muscle spasms Twitches Chest pains

Tension Back pain Rapid heart beat

Sexual disturbances Tremors Don’t like being touched

Unable to relax Fainting spells Blackouts

Bowel disturbances Hear things Excessive sweating

Tingling Watery eyes Visual disturbances

Numbness Flushes Hearing problems

Menstrual History: (if applicable)

Age of first period:       Were you informed or did it come as a shock?

Are you regular?       Date of last period

Duration?       Do you have pain with your period?

Do your periods affect your mood?      .

**What sensations are especially**:

Pleasant for you

Unpleasant for you?

**7. Images:**

**Boldface or circle** any of the following that apply to you. **Do you have**:

Pleasant sexual images Unpleasant sexual images

Unpleasant childhood images Lonely images

Helpless images Seduction images

Aggressive images Images of being loved

**Place an X** next to any of the following that applies to you. **I picture myself**:

being hurt       hurting others

not coping       being in charge

succeeding       failing

losing control       being trapped

being followed       being laughed at

being talked about       being promiscuous

others:

What picture comes into your mind most often?

Describe a very pleasant image, mental picture or fantasy

Describe a very unpleasant image, mental picture or fantasy

Describe your image of a completely “safe place

How often do you have nightmares?

**8. Thoughts:**

**Place an X** next to each of the following thoughts that apply to you:

I am worthless, a nobody, useless and/or unlovable.

I am unattractive, incompetent, stupid and /or undesirable.

I am evil, crazy, degenerate and /or deviant.

Life is empty, a waste; there is nothing to look forward to.

I make too many mistakes, cant’ do anything right.

**Boldface or circle** each of the following words that you might use to describe yourself:

Intelligent, confident, worthwhile, ambitious, sensitive, loyal, trustworthy, full of regrets, worthless, a nobody, useless, evil, crazy, morally degenerate, considerate, a deviant, unattractive, unlovable, inadequate, confused, ugly, stupid, naïve, honest, incompetent, horrible thoughts, conflicted, concentration difficulties, memory problems, attractive, can’t make decisions, suicidal ideas, persevering, good sense of humor, hard-working.

What do you consider to be your most irrational thought or idea?

Are you bothered by thoughts that occur over and over again?

On each of the following items, **NUMBER** the one that most accurately reflects your opinions:

STRONGLY STRONGLY

DISAGREE DISAGREE NEUTRAL AGREE AGREE

1 2 3 4 5

I should not make mistakes.

I should be good at everything I do.

When I do not know, I should pretend that I do.

I should not disclose personal information.

I am a victim of circumstances.

My life is controlled by outside forces.

Other people are happier than I am.

It is very important to please other people.

Play it safe; don’t take any risks.

I don’t deserve to be happy.

If I ignore my problems, they will disappear.

It is my responsibility to make other people

happy.

I should strive for perfection.

Basically, there are two ways of doing things-

the right way and the wrong way.

Expectations regarding therapy:

In a few words, what do you think therapy is all about

How long do you think your therapy should last?

How do you think a therapist should interact with his or her clients

What personal qualities do you think the ideal therapist should possess? ­­­­­­­­­­­­­­­

Please complete the following:

I am a person who

All my life

Ever since I was a child

It’s hard for me to admit

One of the things I can’t forgive is

A good thing about having problems is

The bad think about growing up is

One of the ways I could help myself but don’t is

A. Family of Origin:

1. If you were not brought up by your parents, who raised you and between what years?
2. Were you adopted? If so at what age?
3. Give a description of your father’s (or father substitute’s) personality and his attitude towards you (past and present):

Give a description of your mother’s (or mother substitute’s) personality and her attitude toward you (past and present

In what ways were you disciplined (punished) by your parents as a child

(3) Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and between children.

(4) Were you able to confide in your parents?

(5) Did your parents understand you?

(6) Basically, did you feel loved and respected by your parents?

1. If you have a step-parent, give your age when parent remarried.
2. Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?
3. Who are the most important people in your life?

B. Friendships:

1. Do you make friends easily?
2. Do you keep them?
3. Were you ever bullied or severely teased?
4. Describe any relationship that gives you:

* Joy:
* Grief:

1. Rate the degree to which you generally feel comfortable and relaxed in social situations: Very relaxed       Relatively comfortable       Relatively uncomfortable       Very anxious

Generally, do you express your feelings, opinions and wishes to others in an open, appropriate manner?

Describe those individuals with whom (or those situations in which) you have trouble asserting yourself?

1. Did you date much during High School?       College?
2. Do you have one or more friends with whom you feel comfortable sharing your most

private thoughts and feelings?

C. Marriage:

1. How long did you know your spouse before your engagement?
2. How long have you been married?
3. What is your spouse’s age?
4. What is your spouse’s occupation?
5. Describe your spouse’s personality.
6. In what areas are you compatible?
7. In what areas are you incompatible?

How do you get along with your in-laws (this includes brothers and sister-in-law)?

1. How many children do you have?       Please give their names, ages and sexes:

1. Do any of your children present special problems?

Any relevant information regarding abortions or miscarriages?

D. Sexual Relationships:

1. Describe your parents’ attitude toward sex. Was sex discussed at home?
2. When and how did you derive your first knowledge of sex?

1. When did you first become aware of your own sexual impulses?

Have you ever experienced any anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain.

Any relevant details regarding your first or subsequent sexual experiences?

Is your present sex life satisfactory? If not, please explain.

Provide information about any significant homosexual reactions or relationships

E. Other Relationships:

1. Are there any problems in your relationships with people at work? If so, please describe.
2. Please complete the following:
   1. One of the ways people hurt me is
   2. I could shock you by
   3. A mother should
   4. A father should
   5. A true friend should
3. Give a brief description of yourself as you would be described by:
   1. Your spouse (if married):
   2. Your best friend:
   3. Someone who dislikes you:
4. Are you currently troubled by any past rejections or loss of a love relationship? If so, please explain.

**10. Biological factors:**

Do you have any current concerns about your physical health? Please specify:

Please list any medicines you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter)

Do you eat three well-balanced meals each day? If not, please explain:

Do you get regular physical exercise? If so, what type and how often?

Put a number in the box following those things that apply to you:

VERY

NEVER RARELY FREQUENTLY OFTEN

1 2 3 4

Marijuana

Tranquilizers

Sedatives

Aspirin

Cocaine

Painkillers

Alcohol

Coffee

Narcotics

Stimulants

Hallucinogens (LSD, etc.)

Diarrhea

Constipation

Allergies

High Blood Pressure

Heart problems

Nausea

Vomiting

Insomnia

Headaches

Backache

Early morning awakening

Fitful sleep

Overeating

Poor appetite

Eat “junk foods”

**Underline** any of the following that apply to you or members of your family:

thyroid disease, kidney disease, asthma, neurological disease, infectious diseases, diabetes, cancer, gastrointestinal disease, prostate problems, glaucoma, epilepsy, Other:

Have you ever had any head injuries or loss of consciousness? Please give details.

Please describe any surgery you have had (give dates):

Please describe any accidents or injuries you have suffered (give dates):

**Sequential History:**

Please outline your most significant memories and experiences within the following ages: