New Day Counseling - Life History Self-Report Form Adult

The purpose of this form is to obtain a comprehensive understanding of you—your life experience and background. In answering the following questions as accurately and completely as you can, you will facilitate in the development of a treatment plan that is best suited to your individual needs.

Please print clearly. If you need more space for any of the questions, please use the back of the sheet.

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Ok to leave message? Home: ☐ yes ☐ no Work:☐ yes ☐ no Cell:☐ yes ☐ no **Email address:**_____

Ok to send mail? Home: ☐ yes ☐ no Email: ☐ yes ☐ no

Birthdate _____ Age _____ Gender _____F _____M

Race (optional): ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Caucasian ☐ Other _____

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medical History

How do you rate your present physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any medical problems you are currently experiencing:_____

_____

List any medications you are currently taking:

Name of medication	Dosage	Frequency	Reason

CHECK ANY OF THE FOLLOWING THAT MAY BE OF CONCERN TO YOU:

___Coping and/or Adjusting ___ Sleeping Problems ___Current Emotional State ___Sexual Concerns ___Depression ___ Past Trauma, Loss, Grief ___Fears/Phobias ___Trauma Related to Physical ___Anxiety ___Sexual Abuse, Rape or Incest ___Anger/Self-Control ___Health Problems, Nutrition ___Substance Abuse ___Eating Disorder ___Relationship(family, couple, other) ___Vocational ___Divorce Adjustment ___Education/Career ___Suicidal Thoughts ___Legal Matters ___Addictive Behaviors (drugs, alcohol, food, gambling, pornography, shopping..) ___Finances Other: _____

What is happening in your life that resulted in this appointment? _____

_____

What areas of your life are being affected by the above?

___Social ___Physical ___Occupational ___Academic ___Emotional ___Behavioral

Please check the word that best describes the severity of your problem:

___Mild ___Moderate ___Severe ___Extremely Severe ___Totally Incapacitating

When did your problems begin? _____

What seems to worsen your problems? _____

What have you tried that has been helpful? _____

What would you like to see accomplished in therapy? _____

SERVICES DESIRED: ___Individual Counseling ___Group Therapy ___Family Counseling ___Assessment and Referral ___Couple Counseling ___Other: _____

Personal Health History

Have you ever had thoughts of suicide (killing yourself)? ☐Yes ☐ No

If yes, when?_____

Have you ever taken any action toward ending your life? ☐Yes ☐ No
If yes, please explain: _____

Have you ever had thoughts or plans of homicide (killing someone else)? ☐Yes ☐ No
If yes, please explain:_____

Do you feel suicidal or homicidal at this time? ☐Yes ☐ No If yes, explain_____
_____

Family Information

Your current relationship status: ☐ Single ☐ Never married ☐ Divorced/Annulled [Date(s) _____ Reason_____

☐ Divorce in process ☐ Separated ☐ Widowed ☐ In committed relationship-How long? _____Living together?_____

☐ Engaged ☐ Married (How long? _____ Are you satisfied with your marriage? ☐ yes ☐ no

Assessment of relationship with significant other (if applicable) ☐ Good ☐ Fair ☐ Poor ☐ Other _____

	Name	**Age**	**Living?** If "no" Cause of death, year, & your age at the time	**Living with you?** *Yes or No*	**Step** *or* **Adopted Relationship** *Yes or No*
Spouse					
Children:					
Mother					
Father					
Siblings:					

Parents:☐ Married ☐ Separated ☐ Living Together ☐ Divorced-Your age at time of divorce: ____

City/State of childhood residence: _____

Were you adopted? ☐ Yes ☐ No *If yes,* from what age did you know? _____

If you were not brought up by your parents, who raised you? Between what years? _____

FATHER – Occupation: _____Highest Level of Education:_____
General Status of Health (physical):_____(emotional):_____
Nationality: _____ Describe Relationship:_____
_____

MOTHER– Occupation: _____Highest Level of Education:_____
General Status of Health (physical):_____(emotional):_____
Nationality: _____ Describe Relationship:_____
_____

SIBLINGS: What is your birth order (oldest, youngest, middle, only child?) _____
Describe Relationships- Is there anyone that you are particularly distant from or close with? Have problems with?

_____
_____

Does anyone in your family suffer from a mental or emotional disorder (depression, anxiety, alcoholism, schizophrenia, etc.)? ☐ Yes ☐ No Please explain:_____
_____

Has any one of your relatives ever attempted or committed suicide? ☐Yes ☐ No

Are there traumatic, unusual, or special circumstances that occurred in your life? ☐Yes ☐No
If yes, please describe _____

Has there been a history of child abuse? ☐Yes ☐ No
If yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal ☐ Other: _____

Parenting style of parents:

☐ Authoritative (fair) ☐ Authoritarian (overly strict) ☐ Permissive (few rules)

Education

What is the last grade of school you completed or highest degree?_____

Are you in school now? ☐ Yes ☐ No *If yes,* where?_____Major?_____

Other training:_____Strengths:_____Weaknesses:_____

Average school grades _____ Favorite areas of study:_____ Least favorite _____

Work History

Current Employment Status:

☐FT ☐PT ☐Temp ☐Laid-off ☐Disabled ☐Retired ☐Social Security ☐Student ☐Other:_____

What type of work do you do? _____Current Employer _____

Are you satisfied with the type of work you do? ☐ Yes ☐ No *If no*, please explain: _____

_____

What kinds of jobs have you held in the past? _____Reason(s) you left_____

Employment Status and type of work of your Significant Other?_____

Do you do any volunteer work? ☐ Yes ☐ No *If yes,* explain:_____

Military

Military service? ☐Yes ☐ No Branch _____ # of Tours _____ Combat experience? ☐Yes ☐ No

Discharge date _____ Type of Discharge_____ Rank at discharge _____

Family member in the service? ☐Yes ☐ No Who? _____

Counseling History

Have you ever sought help from a counselor, psychologist, psychiatrist, pastor, or other professional?

☐ Yes ☐ No *If yes:* where, when, and for what?_____

Was it helpful? ☐ Yes ☐ No Explain: _____

Have you ever been hospitalized for emotional reasons? ☐ Yes ☐ No *If yes,* please explain.

_____

Social Relationships

How do you describe your interactions with others?

☐ Leader ☐ Follower ☐ Friendly ☐ Outgoing ☐ Shy ☐ Uncomfortable ☐ Guarded ☐ Aggressive
☐ Affectionate ☐ Withdrawn ☐ Submissive ☐ People Pleaser ☐ Bossy Other _____

Sexual Orientation: ☐ heterosexual ☐ homosexual ☐ bisexual Comments:_____

Do you currently have supportive friendships? ☐ Yes ☐ No Comments_____

Do you have a history of social problems? ☐ being bullied ☐ bullying others ☐ being abused – what type

of abuse (circle all that apply) emotional, sexual, physical, verbal ☐ abusing others

Self Care

How many hours do you sleep in a typical night? _____hours Any problems: ☐ Falling asleep ☐ Staying asleep

Do you exercise on a regular basis? ☐ Yes ☐ No How often? _____times per week/ _____ times per month

Are you currently on a diet? ☐ Yes ☐ No Explain _____

Describe your current eating habits _____

Leisure/Recreational

Describe hobbies or special interests you have (e.g., physical fitness, cooking, sports, arts, crafts, outdoor activities, music, traveling, dancing, concert-going, theatre, hunting, fishing, swimming, etc.)

Activity	How Often Now?	How Often in the Past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you consider your lifestyle: ☐ work oriented ☐ family oriented ☐ self-oriented ☐ people oriented
☐ leisure oriented ☐ recreational oriented

Spiritual/Religious

How important are spiritual matters to you? ☐ Not at all ☐ Somewhat ☐ Important ☐ Very Important

Are you affiliated with a spiritual or religious group (church, synagogue, temple, other)? ☐Yes ☐ No
If yes, describe _____

Were you raised with a spiritual/religious upbringing? ☐Yes ☐ No *If yes,* describe _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐Yes ☐ No

Current Legal Status and History

Are you involved in any active cases? (traffic, civil, criminal)? ☐Yes ☐ No

If yes, please describe and indicate court and hearing/trial dates and charges _____
_____

Are you currently on parole or probation? ☐Yes ☐ No

If yes, please describe _____

Have you ever had any traffic violations in the past? ☐Yes ☐ No DWI, DUI, etc. ☐Yes ☐ No

Criminal involvement ☐Yes ☐ No Civil involvement ☐Yes ☐ No

If yes, please describe charges, dates and results _____
_____

Substance Use History

Please list any recreational chemicals that you currently use or have used in the past (alcohol, marijuana, cocaine, crack, sedatives, tranquilizers, painkillers, barbiturates, heroin, ecstacy, hallucinogens, etc.)

_____

Current substance of preference _____

When and where was your last drink/drug use? _____How much?_____

Check the items below that describe your present drinking/drug use pattern:

☐ No use	☐ Irregular & excessive	☐ Rarely (once a month)
☐ Regularly (daily)	☐ Short binges (1-2 days)	☐ Only on holidays
☐ Heavy (daily)	☐ Long binges (4+ days)	☐ Occasionally (weekends)

Reason(s) for use: ☐ Addicted ☐ Build confidence ☐ Socialization ☐ Taste ☐ Relaxation/Unwind
☐ Escape ☐ Self-medication ☐ Other (specify):_____

Have you ever received professional treatment for drug/alcohol problem (include AA)? ☐Yes ☐ No
If yes, when?_____

Nature of treatment: ☐ Inpatient ☐ Outpatient ☐ Detoxification ☐ Self-help

Do you think, now or in the past, you have a drinking/drug abuse problem? ☐Yes ☐ No

Has anyone ever expressed concern about your drinking/drug use? ☐Yes ☐ No
If yes, please explain: _____

Does anyone in your family currently have a drug/alcohol problem? ☐ Yes ☐ No
If yes, please explain: _____

Do you smoke cigarettes, chew tobacco, vape, other? _____

Is there anything else you would like to share that was not included in this form, please use the space below and/or back of this sheet.

_____
_____
_____
_____
_____

Signature _____ **Date**_____