Adult Life History Questionnaire

Bren J Fraser M.A. MFT 45649 Licensed Marriage and Family Therapist

805-965-0448

Legal Name ____

Preferred Name: ____

Date of Birth: ____/_____/_____

Sex Assigned at Birth: • M • F • Intersex ____________________

Gender: • M • F • Other ________________________________

Pronouns: • He/Him/His • She/Her/Hers • They/Their/Theirs • Other

Do you have a faith-based or spiritual practice? ________________

Address:____

____

Phone number(s) / Email address:_____________________________

____

Emergency Contact:______________________________________

Marital Status: • Married • Single • Divorced • Separated • Remarried
• Committed relationship • Partnered • Widowed

Education/Highest Grade Completed:___________________________

Occupation/Employer: ____________________________________

Presenting problem/reason for seeking treatment:

Besides therapy, how have you tried to manage this problem?

Adult Life History Questionnaire

Previous Psychiatric Treatment: • None • Outpatient • Inpatient

• Please describe (reason for treatment, clinician, dates of treatment, outcome:)

Psychiatrist's Name: ________________Psychiatrist's Phone #: _________

Physician's Name: _________________ Physician's Phone #: ___________

Medical conditions:

Allergies:

Medications:

Symptom Checklist

• Victim of abuse	• Compulsive spending
• Neglect	• Compulsive sexual relationships
• Unresolved grief/loss	• Weight loss/gain Binge eating
• Irritability	• Not eating to lose weight
• Excessive sadness	• Trying to lose weight by vomiting or exercising excessively
• Loss of enjoyment of usual activities	• Feelings of detachment
• Low self-esteem	• Hearing voices
• Tiredness, fatigue	• Excessive physical pain
• Withdrawn, isolation	• Seeing things that aren't there
• Feelings of emptiness	• Hair-pulling
• Difficulty sleeping	• Impulsivity
• Panic	• Disorientation
• Expressing a wish to die	• Difficulty finishing tasks
• Poor concentration	• Difficulty paying attention
• Excessive worry	• Excessive daydreaming
• Thoughts/attempts of suicide	• Stealing
• Excessive fears (phobias)	• Lying Hyperactivity
• Nervousness	• Recurring problems with the law
• Workaholic behavior	• Destroying property
	• Cigarette use

Adult Life History Questionnaire

• Repeating an act over and over that is unnecessary (e.g., washing, checking, counting) • Overly concerned about germs, safety, or health • Excessive need for order, cleanliness • Overly concerned with details • Easily annoyed • Mood swings • Temper outbursts Argumentative • Violent fantasies/impulses • Harmful to others • Periods of time with very high energy level • Talking or thinking too fast • Paranoia • Poor body image	• Alcohol use: _______ per week • Drug use • Questions or concerns with your sexuality • Questions or concerns with your gender or gender expression • Participating in high-risk sexual activity • Difficulty performing sexual activity • Feel guilty about sex • Relationship problems • Overly sensitive to criticism • Overreactive • Fear of rejection • Difficulty trusting

Please indicate the degree of distress you are experiencing at this time:

•Mild • Moderate • Severe

Please describe any notable mental health or behavioral issues of family/relatives

What else do you want me to know about you?

Date:______________________ Signature:__________________