

# 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 (optional): \_\_\_\_\_

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 (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name (2) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## **Family Information**

Your current relationship status:

Single  Never married

In committed relationship (How long? \_\_\_\_\_ Living together? \_\_\_\_\_)

Engaged

Married (How long? \_\_\_\_\_ Are you satisfied with your marriage?  yes  no )

Divorced/Annulled [Date(s) \_\_\_\_\_ Reason \_\_\_\_\_]

Divorce in process

Separated  Widowed  Other \_\_\_\_\_

Assessment of relationship with significant other (if applicable)  Good  Fair  Poor  Other \_\_\_\_\_

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

City and State of major childhood residence: \_\_\_\_\_

Parents:  Married  Separated  Living Together  Divorced (Your age at time of divorce: \_\_\_\_)

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

**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:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____

**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 \_\_\_\_\_  
\_\_\_\_\_

**Self Care**

How many hours of sleep do you receive in a typical night? \_\_\_\_\_ hours

Any problems:  Falling asleep  Staying asleep

Do you exercise on a regular basis?  Yes  No Explain \_\_\_\_\_

How often? \_\_\_\_\_ times per week/ \_\_\_\_\_ times per month and typically \_\_\_\_\_ min/hours

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.)

<u>Activity</u>	<u>How Often Now?</u>	<u>How Often in the Past?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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, ecstasy, 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** \_\_\_\_\_