Janet Bergsgaard, M.Ed., M.M.F.T.
Marriage and Family Therapist

Date: ________________________

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain some information about you so that I can better meet your request for service. Completing this questionnaire as fully and as accurately as you can facilitate the development of your therapy experience.

It is understandable that you may be concerned about what happens to this information about you, because this information is highly personal. Please be assured that all material in your file is confidential and will be managed in strict accordance with the legal and ethical guidelines of the American Association of Marriage and Family Therapists.
If you prefer not to answer any question, just write: N/A (No answer). If you need extra space, use reverse side of page.

1. General Information (please print)

Name: ____ **OPTIONAL**

Address: ____
Postal code: _____________________

Telephone:(home)___________(office) ___________(cell) ___________
Permission to leave message? home: Yes/No office: Yes/No cell: Yes/No

Age: ___________Date of Birth: ___________

Education: ____
Occupation and employment situation: ____
____

Relationship Status: (circle one - the following items apply to both heterosexual and homosexual relationships):
Single, Married, Common-Law, Separated, Divorced, Remarried, Widowed

If you have a partner:
How long have you been together? __________
How long have you been living together? _________
Age of partner: _______
Education and occupation of partner: ____

Do you have children? □Yes □No
If yes, how many live with you? ______________________________
Please list your children's names, age (birth dates) and gender: __________________________
____

2. **Medical History**

Name of family physician:___________________________________

Telephone number:___________________________________

Do you intend to inform your medical doctor that you are attending therapy? □Yes □No

Do you currently have any medical problems that require treatment? □Yes □No

If YES, please describe the problem and nature of the treatment:

Are you taking any medication at this time? □Yes □No

If YES, please list (include both prescription & non-prescription medication):

What other serious medical problems or accidents have you had?

Do you have any special physical needs? (please describe)

3. **Chemical Use/Gambling/Internet:**

Do you use recreational drugs? □Yes □No If YES, please list: ______________________________

If YES, how frequently do you use drugs? ____

How frequently do you use alcohol? ____

How much beer, wine or hard liquor do you consume each week?______________________________

Have you ever been criticized for your drinking or drug use?__________________________________

Have you ever felt guilty for your alcohol or drug use?_______________________________________

How do drugs and/or alcohol affect you?____

Have you ever had any concerns about your gambling practices? ______________________________

Do you have any concerns regarding a family member's drug or alcohol use, or gambling?___________

Have you ever had any concerns about your use of the Internet, e.g., excessive time spent, relationships established through social networks, pornography, etc. ______________________________

Have you ever had any concerns about a family member's use of the Internet? ______________________

4. **Social Network**

Do you have someone with whom you can share personal problems? □Yes □No

If yes, who is it? ____

How do you spend your leisure time?

____

Do you belong to any clubs or organizations (e.g. religious groups, sports activities, parent/school organizations, etc…)?

5. Family History

Relative: Name | Current age (or age at death) | Illness (or cause of death) | Education | Occupation

Father: ____

Mother: ____

Others(stepparents/grandparents):

____

____

Siblings: ____

____

If you were to choose three adjectives to describe your mother, as you were growing up, what would they be?______________, ______________, __________.

What sort of relationship did you have with your mother? ______________________

____

If you were to choose three adjectives to describe your father, as you were growing up, what would they be?______________, ______________, __________.

What sort of relationship did you have with your father? ______________________

____

Comment on any significant relationships that have been influential in your experience growing up. (Use reverse side if necessary):

6. Relationship History:

Partner's name	Partner's age when relationship began	Partner's age when relationship ended	Your age when relationship ended
1.:			
2.:			
3.:			

Current Relationship:

Level of commitment to relationship:

1 2 3 4 5

Low High

(Circle number)

Level of distress in relationship:

1 2 3 4 5

Low High

7. Other Information

Do you have difficulty sleeping? □Yes □No

Have you ever been: (circle)

Physically abused Emotionally abused Sexually abused

Is there any other information you think may help me understand you?

8. Expectations for Therapy

What prompted you to seek therapy at this time?

What changes would you like to make?

On the back of this page, please make a list of important dates that have affected you and those close to you, i.e., birthdates, death dates, marriages, divorces, illnesses (mental and physical), moves, major accidents, career changes – anything that had a significant impact on you and those close to you over your lifetime going back to grandparents/great grandparents if possible. Also please note your cultural background.

Where did you hear about me? (Circle one:) Friend Family member Professional referral Website Newspaper ad Other _________________

Thank you for taking time to complete this form.