Gary M. Eisenberg, Ph.D.

Licensed Clinical Psychologist #PSY 3907
609 W. Littleton Blvd Suite 307
Littleton, CO
303-808-4140

LIFE HISTORY QUESTIONNAIRE

Name:_____ Date: _____

Home #:_____ Work #:_____ Cell #: _____

Address: _____ City:_____State:____ Zip:_____

Email Address:_____ _____

Age:_____ Date of Birth: _____ Birthplace: _____

Occupation:_____ SS#:_____

Employer:_____ Religious Affiliation: _____

Marital Status: (circle one)

Single Married Separated Divorced Widowed Remarried

By whom were you referred? _____

Household Members, their relationship to you, their age? _____

_____

Health during Childhood:_____

Health during Adolescence: _____

Any surgical operations (list age at time): _____

_____

Any accidents (list age at time): _____

_____

Where were you raised: _____

_____

Doctor and date of last physical exam: _____

State in your own words the nature of your main problems and their duration: _____

_____

_____

FAMILY DATA:

Father living? _____ Age: _____

If living, present health:

_____

If deceased, cause of death:

_____

Your age at time of his death _____

His occupation _____

Briefly describe your relationship with your your father:

_____

_____

Mother Living? _____ Age: _____

If living, present health:

_____

If deceased, cause of death:

_____

Your age at time of her death _____

Her occupation _____

Briefly describe relationship with your mother:

_____

_____

Siblings:

Number of brothers: _____ Brother's ages: _____

Number of sisters: _____ Sister's ages: _____

Briefly describe your relationship with your siblings: _____

_____

Were you able to confide in your parents: _____

If you have a step-parent, give your age when parent remarried: _____

_____

Briefly describe your relationship with your step-parent: _____

_____

Who are the most important people in your life? _____

_____

Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"? If so, please give details: _____

_____

_____

_____

_____

Circle any of the following that apply to you:

Headaches	Dizziness	Fainting Spells
Palpitations	Stomach trouble	No appetite
Bowel disturbances	Fatigue	Insomnia
Nightmares	Take sedatives	Alcoholism
Feel tense	Feel panicky	Tremors
Depressed	Suicidal Ideas	Take drugs
Unable to relax	Sexual difficulties	Shy with people
Don't like weekends or vacations	Overambitious	Can't make decisions
	Inferiority feeling	Home conditions bad
Can't make friends	Memory problems	Financial problems
Concentration difficulties	Unable to have a good time	Can't keep a job

AND – Others: _____

_____

List any regular medications, dosages and prescribing doctor:_____

_____

Present interests, hobbies and activities: _____

_____

Kinds of jobs held in the past: _____

_____

Do you make friends easily? _____

<u>MARITAL HISTORY</u>:

How long have you been married?_____

Husband's/wife's age:_____ Name: _____

Occupation of spouse: _____

If there was a previous marriage, give dates and reason(s) for dissolution: _____

_____

How many children do you have? _____ Please list names and ages: _____

_____

Do any of your children present special problems? _____

If so, please describe: _____

_____

_____

Are there any other members of the family about whom information regarding illnesses, relationships, etc., is relevant? If so, please give details: ___________________________

____

List any situations that make you feel particularly anxious: _________________________

____

List any situations which make you feel calm or relaxed: ___________________________

____

List the benefits you hope to derive from therapy: ________________________________

____

Please give completed questionnaire to the doctor or receptionist. Thank you.

- -

AUTHORIZATION FOR RELEASE OF INFORMATION

This is to authorize ____

to release any information regarding ____

to ____

I understand that this information will be kept confidential.

____
Patient's Signature

____
Print Name

____
Date