Counseling Center for Wellness

Life History Questionnaire

(All files are held in strict confidence)

Student ID _____ Date_____ Counselor preference _____

First Name_____ MI ____ Last Name _____ Maiden _____

Age _____ Date of Birth _____ Gender: _____

Ethnicity:	Relationship Status:		
Campus PO Box			
Local Address	City	State	Zip
Local Phone May we leave a message? Yes ◯ No ◯	E-mail Address	May we send a message? Yes ◯ No ◯	
Permanent Address	City	State	Zip
Permanent Phone	May we leave a message? Yes ◯ No ◯	Hrs. per wk. in paid employment	
Major	Minor	Cumulative GPA	
I am currently in my ◯ 1st ◯ 2nd ◯ 3rd ◯ 4th ◯ 5th ◯ 6th + yr. of college	Academic Status ◯ Fr ◯ So ◯ Jr ◯ Sr	Advisor	

☐ Please mark this box if you are currently on academic probation.

☐ Please mark this box if you have ever been on academic probation in the past.

Number of Credits This Semester: _____

Please indicate who referred you to the Counseling Center **Referral Name**

Referral Type ◯ Self ◯ Faculty ◯ Residence Life Staff ◯ Other Staff ◯ Friend ◯ Family ◯ Healthcare Provider ◯ Other

Please read the following questions and mark those to which you would respond "yes."

- ☐ Have you previously been involved in counseling?
- ☐ Do you currently use alcohol or other non-prescription drugs?
- ☐ Is there a history of mental health problems in your family?
- ☐ Have you ever been physically abused?
- ☐ Have you ever been emotionally abused?
- ☐ Are your concerns interfering with your academic performance?
- ☐ Have you ever attempted suicide?
- ☐ Have you ever been hospitalized for mental health reasons?
- ☐ Is there a history of alcohol or drug problems in your family?
- ☐ Have you ever been in legal trouble?
- ☐ Have you ever been sexually abused or assaulted?
- ☐ Are you currently taking any prescription medication?
- ☐ Are your concerns interfering with your ability to stay in school?

Please describe the concerns you would like to discuss with a counselor:

How long has this problem persisted?

Are you currently in danger of seriously harming your life or someone else's? No ◯ Yes ◯

Rate the severity of your problem on a scale of 1-10, 10 being the most severe

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Please use the following scale to answer the next three questions:

	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History

Mother's Age _____ If deceased, how old were you when she died? _____

Father's Age _____ If deceased, how old were you when he died? _____

If your parents are separated, how old were you then? _____

Number of brother(s) _____ What are their ages? _____ _____ _____ _____

Number of sister(s) _____ What are their ages? _____ _____ _____ _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:

Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

Briefly describe your past and current relationships with your:

Mother

Father

Stepmother

Stepfather

Religious Affiliation

☐ Jewish
☐ Catholic
☐ Protestant _____
☐ None, but I believe in God
☐ Atheist or agnostic
☐ Other _____

Do you desire to have your religious beliefs and values incorporated into the counseling process?

☐ Yes ☐ No ☐ Not Sure

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts
- ☐ Other _____

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest
- ☐ Other _____

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you: