SYMATREE

LIFE HISTORY INVENTORY

This inventory has two purposes: 1. to allow your therapist to obtain a comprehensive picture of your background, and 2. to give you an opportunity to reflect on issues that have brought you to therapy. Please answer all questions as fully and accurately as you can. Give yourself enough time to think about them before answering. If a question does not pertain to you, put N/A ("not applicable") in the blank. This inventory is strictly confidential.

Date: _____
Name: _____ Age:

PRESENTING CONCERNS:
State, in your own words, your main problem(s) and how long you have had it (them):
_____
_____
_____
_____
_____

Who referred you here? _____
Why did this person refer you? _____
_____

Previous mental health professionals you have seen:

Name of Therapist, Treatment Facility, or Hospital	Dates Seen	Nature of Problem	Result of Treatment

Have you ever tried to harm yourself? _____
If yes, please list when, how, and the result. _____
_____

Have you ever been violent toward someone else? _____ Who? _____
Describe the circumstances: _____
_____

List any medications or prescription drugs that you currently are taking:

Medication	Dosage	Reason for medication	Compliant?

HISTORY OF CHEMICAL USE
Check all the drugs you have used:
_____ Alcohol _____ Marijuana _____ Cocaine _____ Crack _____ LSD
_____ Methadone _____ PCP _____ Inhalants _____ Methamphetamine (Crystal Meth)

_____ Amphetamines (speed, white cross, black beauties, Molly's, etc.)
_____ Sedatives, Tranquilizers (sleeping pills, ludes, Valium, Xanax, Ativan, etc.)
_____ Barbiturates "Downers" (blue tips, reds, yellow jackets, etc.)
_____ Narcotics / Opiates (heroin, morphine, Dilaudid, Vicodin, etc.)
_____ Over-the-Counter
_____ Tobacco (In what form _____)
_____ Other drugs _____
List any current alcohol or drug use: _____
Date of last use (which drug and when): _____
Frequency of use: _____
Previous chemical dependency assessment or treatment? _____ If so, where, when, and did you complete treatment? _____
Have you ever attended AA? _____ NA? _____ Al-Anon? _____ ACOA? _____

MEDICAL HISTORY
Height: _____ Weight: _____
Activity level? _____ Low _____ Moderate _____ Active
How is your health? _____ Poor _____Fair _____ Good _____ Excellent
Describe any serious illnesses or medical conditions you have or have had: _____
_____
_____
Describe any accidents or operations you have had at any time of your life: _____
_____
_____
Describe any health problems you have had within the last 60 days, such as dizziness, fainting, vomiting, diarrhea, vision changes, dental problems, sleep problems, etc.: _____
_____
_____
Physician's name, address, and phone number: _____
_____
When did you last see a physician for any reason? _____ Why? _____
List problems during your mother's pregnancy, labor, and/or delivery, as well as any developmental delays you had: ____
_____
_____
Have any of the following event happened recently:
_____ Death in family _____ Death of friend _____ Death of pet _____ Move
_____ Separation/divorce _____ Employment change _____ Abuse of child _____ Domestic violence
_____ Other significant life event(s):_____

FAMILY HISTORY
Please list people who currently reside in your home:

Name	Age	Relationship to Client	Occupation	How you get along

Please list significant family members or people in your life who do not reside in your home:

Name	Age	Relationship to Client	Occupation	How you get along

Family of Origin

Family Member	Name	Age	Education	Occupation	How you get along	Alcohol/drug problems	Mental health problems	Health problems
Mother								
Father								
Step-mother								
Step-father								
Sibling								
Sibling								
Sibling								

If your parents are living, what is the state of their health?
Mother: _____ Father: _____
Date and cause of death: Mother _____ Father: _____
If your parents did not raise you, who did? _____
What is/was your relationship like with that person(s)? _____
_____
Is there any other information about yourself or your family of origin that is relevant to your therapy? If yes, please describe: _____
_____

MARITAL / RELATIONSHIP HISTORY

_____ Single / never married _____ Married _____ Engaged _____ Widowed
_____ Living together _____ Separated _____ Divorced

Name of spouse / current partner: _____
How long have you been together? _____
Describe your relationship with your spouse / partner: _____
_____
Have you ever been separated? _____ How many times? _____ How long? _____
Reason(s) for separation? _____

Have you ever been divorced? _____ How many times? _____
Reason(s) for the divorce(s)? _____
Has your current spouse / partner been married before? _____ How many times? _____
Reasons for the divorce(s)? _____
Do your children live with you? _____ If not, with whom do they live? _____
Do you have shared parenting? _____ Visitation? _____
Any concerns about your children or parenting your children? If yes, please explain. _____
_____

EDUCATIONAL HISTORY

_____ Less than high school graduate (highest grade completed _____) _____ High school graduate
_____ GED (last grade completed _____) _____ Associates degree or some college
_____ College degree, specify _____
_____ Vocational, technical, or business training _____
_____ Currently in school (where? _____)

Check any problems you experienced in school:

_____ Missing/skipping class _____ Tardiness _____ Low grades _____ Held back a grade
_____ Suspended/expelled _____ Problems reading/writing _____ Problems with other students
_____ Problems with teachers/professors _____ Other, describe_____

Describe your academic abilities, strengths, and weaknesses _____
_____

VOCATIONAL HISTORY

Please list your job history. Include dates of employment, name of employer, and what you did. _____
_____
_____
_____
Please list current employment, if applicable. _____
Are you satisfied or unsatisfied with current work? _____ List reasons: _____
_____
Does your income meet your financial needs? _____ Why or why not?_____

LEGAL HISTORY

Have you ever had trouble with the law? If so, please explain. _____
_____
Current involvement in the legal system (criminal, civil, juvenile, etc.)? If so, please explain. _____
_____

RELIGIOUS HISTORY

Please describe your religious/spiritual beliefs or religion: _____
_____
Do you attend a church, temple, mosque, etc.? _____ How often? _____
Did you attend as a child? _____ How often? _____
How important is your faith to you? _____
Religious/spiritual background of spouse/partner: _____

Do you and your partner agree on religious/spiritual issues/beliefs? _____

SEXUAL HISTORY

What were your parents'/caregivers' beliefs/attitudes about sex? _____

_____

Was sex discussed with you as a child? _____

If not, how did you derive your knowledge of sex? _____

When did you first become aware of your sexual impulses? _____

Have you experienced guilt or anxiety arising from your sexual activities? _____

At what age did you have your first sexual experience? _____

Give details about sexual experiences you have had that you consider relevant to your therapy: _____

_____

Are you satisfied with your current sex life? _____

Have you ever been sexually abused or assaulted? _____ By whom? _____

When? _____ Was this reported? _____

What was the result of the report? _____

**For Females: Age of first period? _____ Number of pregnancies? _____ Number of deliveries? _____

Number of miscarriages? _____ Number of abortions? _____ Given a baby up for adoption? _____

Were you involved in the adoption decision? _____

**For Males: How many children have you fathered? _____ Did the mother(s) deliver the baby? _____

Miscarry? _____ Abortion? _____ Give baby up for adoption? _____ Were you involved in the decisions? _____

PRESENT LIFE

How do you spend your free time? _____

Do you have friends? _____ Do you make friends easily? _____ Do you maintain friendships? _____

Who are the most important people in your life? _____

How often do you spend time or communicate with these people? _____

If you have children, are you satisfied with your relationship with them? Explain. _____

_____

Please complete the following:

I am _____

I feel _____

I think _____

I wish _____

My five main fears are: 1._____ 2._____

3. _____ 4. _____ 5. _____

Describe your earliest memory? _____

Check any that apply to you:

_____ Palpitations	_____ Dizziness	_____ Fainting spells	_____ Headaches	_____ Anxiety
_____ Fatigue	_____ No appetite	_____Tense	_____ Tremors	_____ Depressed
_____ Conflict	_____ Allergies	_____ Lonely	_____ Shy	_____ Anger
_____ Alcoholism	_____ Drug use	_____ Can't relax	_____ Suicidal	_____ No friends
_____ Insomnia	_____ Financial issues	_____ Stomach issues	_____ Panicky	_____ Sex issues
_____ Can't keep job	_____ Nightmares	_____ Inattention	_____ Hyperactive	_____ Hallucinations

_____ Other: _____

EXPECTATIONS FOR THERAPY

What about your present behavior do you want to change? _____

What feelings to you want to alter? _____
What benefits to you expect to get from therapy? _____

What characteristics are you seeking in a therapist? _____

How long do you think your therapy should last? _____
What do you think therapy is about? _____

To whom can you turn for personal support? _____
Will you be able to hold yourself accountable while trying to make changes? _____
Questions you have about therapy or your therapist? _____

Other information you think is pertinent for your therapist to know? _____