

Life History Questionnaire

(All files are held in strict confidence)

Instructions: Your personal information and signed consent to begin counseling is required and it is important to have this information on file. Please print this form, fill out the necessary information, sign and mail to Renewal Ministries of Colorado Springs prior to beginning any counseling. If there are questions that you do not wish to answer write N/A.

First Name		MI	Last Name		
Date of Birth	Height		Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Occupation		<input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Degree Type			
<input type="checkbox"/> Single	<input type="checkbox"/> Cohabiting	<input type="checkbox"/> Engaged	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Spouse		MI	Last Name		
Date of Birth	Anniversary Date		<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Occupation		<input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Degree			

Address		City	State	Zip	-
Home Phone - -	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Phone: - - ext.	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone - -	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact Name & Phone - -		

Who referred you to Renewal Ministries?			Referral Name:		
<input type="checkbox"/> Advertising	<input type="checkbox"/> Pastor	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Physician	<input type="checkbox"/> Other

Previous Counseling History

Have you been in counseling before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes with whom?					
Therapist/Church Name				Phone - -	
Address		City	State	Zip -	
When was your last appointment?			How long were you in counseling?		
Did you take any tests? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure			If yes, list tests taken		
Outcome as you see it?					
May we contact them for information? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <i>If yes please initial here</i>					

Please Read The Following Questions And Mark Any That Apply To You

<input type="checkbox"/> Has there been a significant change in your life?	<input type="checkbox"/> Have you ever been hospitalized for mental health reasons?
<input type="checkbox"/> Do you currently use alcohol or other non-prescription drugs?	<input type="checkbox"/> Is there a history of alcohol or drug problems in your family?
<input type="checkbox"/> Is there a history of mental health problems in your family?	<input type="checkbox"/> Have you ever been in legal trouble?
<input type="checkbox"/> Have you ever been physically abused?	<input type="checkbox"/> Have you ever been sexually abused or assaulted?
<input type="checkbox"/> Have you ever been emotionally abused?	Was it reported <input type="checkbox"/> No <input type="checkbox"/> Yes When

What medication(s) and dosages are you taking?

Doctors Name

Phone - -

Address

City

State

Zip -

Please describe the concerns that you would like to discuss:

How long has this problem persisted?

Under what condition do your problems get worse? Better?

Please Use The Following Scale To Answer The Next Three Questions:

	1	2	3	4
	Not at all	Mildly	Moderately	Highly
1. How serious do you consider your present concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How motivated are you to resolve your concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How optimistic are you that your concern(s) can be resolved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Read The Following Words And Mark Those That Best Describe You

Feelings / Thoughts

<input type="checkbox"/> Helpless	<input type="checkbox"/> Anxious	<input type="checkbox"/> Confused	<input type="checkbox"/> Agitated
<input type="checkbox"/> Depressed	<input type="checkbox"/> Out of Control	<input type="checkbox"/> Unintelligent	<input type="checkbox"/> Obsessive
<input type="checkbox"/> Shameful	<input type="checkbox"/> Fearful	<input type="checkbox"/> Worthless	<input type="checkbox"/> Distracted
<input type="checkbox"/> Angry	<input type="checkbox"/> Emotionally Numb	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Disorganized
<input type="checkbox"/> Guilty	<input type="checkbox"/> Bored	<input type="checkbox"/> Suicidal	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Hopeless	<input type="checkbox"/> Confident	<input type="checkbox"/> Panicky	<input type="checkbox"/> Unloved
<input type="checkbox"/> Lonely	<input type="checkbox"/> Unattractive	<input type="checkbox"/> Useless	<input type="checkbox"/> Sensitive
<input type="checkbox"/> Happy	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Worthwhile	<input type="checkbox"/> Rageful
<input type="checkbox"/> Stressed	<input type="checkbox"/> Inferior	<input type="checkbox"/> Homicidal	<input type="checkbox"/> Self-Conscious
<input type="checkbox"/> Loved	<input type="checkbox"/> Responsive	<input type="checkbox"/> Moody	<input type="checkbox"/> Low Self-esteem

Symptoms / Behaviors

<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Acting Out Sexually	<input type="checkbox"/> Same Sex Attraction
<input type="checkbox"/> Procrastinating	<input type="checkbox"/> Acting Aggressively	<input type="checkbox"/> Marital Conflict
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Disorganization	<input type="checkbox"/> Parent/Child Conflicts
<input type="checkbox"/> Withdrawing Socially	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Lack of Ambition/Goals
<input type="checkbox"/> Decreased Energy	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor Peer Relationships
<input type="checkbox"/> Excessive caffeine/sugar	<input type="checkbox"/> Irritability	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Financial Problems	<input type="checkbox"/> Passivity	<input type="checkbox"/> Worries About Body Image
<input type="checkbox"/> Injuring self	<input type="checkbox"/> Tobacco Use #per day	<input type="checkbox"/> Spiritual Problems
<input type="checkbox"/> Career Problems	<input type="checkbox"/> Compulsivity	<input type="checkbox"/> Dating or Relational Concerns
<input type="checkbox"/> Lustful thoughts	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Excessive Internet or TV Use
<input type="checkbox"/> Masturbation	<input type="checkbox"/> Sexual Dysfunction(s)	<input type="checkbox"/> Gambling/Gaming
<input type="checkbox"/> Pornography	<input type="checkbox"/> Alcohol Use # per day	<input type="checkbox"/> Drinking #Per Week

Physical Symptoms

<input type="checkbox"/> Insomnia	<input type="checkbox"/> Tightness In Chest	<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Tired/Fatigued	<input type="checkbox"/> Dizziness or Light-headedness	<input type="checkbox"/> Excessive Sleep
<input type="checkbox"/> Weight Gain or Loss 10 lbs+	<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Pain - Where?	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Headaches	<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Other

Woman's Issues

<input type="checkbox"/> Miscarriage(s)	<input type="checkbox"/> Abortion(s)	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Menopause
<input type="checkbox"/> Partner of a Sex Addict	<input type="checkbox"/> Other		

Marriage History

Is your spouse willing to come in for counseling? Yes No Uncertain

How long did you know each other before you married?	How old were you when you married? How old was your spouse?
How long did you date before you married?	Years Married
Were you sexually active with each other prior to marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have either of you been unfaithful to each other during your marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been separated from your spouse? Yes No If Yes how long?

As a husband do you feel that your wife respects you? Yes No

As a wife do you feel that your husband loves you? Yes No

Please Give Information About Any Previous Marriages

Husband	Wife

Children's Names	Age	Gender	Living	Education	Marital Status	• PM
			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>

• Check if from a previous relationship

Your Family History

Father's Name	Age	If deceased, how old were you when he died?
Mother's Name	Age	If deceased, how old were you when she died?
If your parents are separated or divorced, how old were you then?		
Number of siblings?	What are their names and ages?	

Briefly Describe Any Relational Problems Where Applicable

Your Father	Spouse
Your Mother	Brothers (Step)
Step Parents	Sisters (Step)
Employer	Other

Religious Affiliation And History

<input type="checkbox"/> Jewish	<input type="checkbox"/> Agnostic, not sure if God exists
<input type="checkbox"/> Catholic	<input type="checkbox"/> Atheist
<input type="checkbox"/> Protestant	<input type="checkbox"/> Other
As a Christian I am detached = 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> = very committed	
I am involved in church detached = 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> = very committed	
Spouse's involvement detached = 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> = very committed	
Do you and your spouse have differing opinions regarding religious issues? <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often	
Ever been involved in cult or occult activities? (i.e. Ouija Board, TM, Yoga, Séances, Horoscopes, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Church Name	Pastor	Phone	-	-
Address	City	State	Zip	-
May we contact your Minister for information? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <i>If yes Please initial here</i>				

Are you or any family member currently involved in any legal proceedings? Yes No

Anything else that you think we should know?

I hereby attest that all the information furnished is true and correct to the best of my knowledge.

Your signature

Date

Email