Sexual Life Improvement, PLLC

~ *From the desk of Shelley L. Imholte, MSW, LCSW, M.Ed., PhD-c*

~State of Texas Social Work Board-approved Supervisor

Voluntary Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary; they permit a more thorough dealing with one's concerns brought into therapy. By completing these questions as fully and as accurately as you can you will facilitate your goals in therapy. You are requested to answer these questions in your own time instead of using psychotherapy session time. It is understandable that you may have concerns about what will happen with this questionnaire because the information is very personal. Records are strictly confidential. Outsiders will NOT have access to your case record without your written permission. If you do not wish to answer a question please indicate so by writing 'Do Not Care to Answer'. Thank you~

Initials: ____ ____ ____ Date: _____

Demographic Information:

Address: _____
_____

Telephone Contact: (days) _____M (evenings)_____M
***please indicate which number a message can be left at by circling the M.*

Email: _____Preference: Y/N

Age: _____ Date of Birth: ___/___/___ Place of Birth: _____

Who referred you? _____

Relationship Status (circle): Single Engaged Married Cohabitating Separated Divorced Widowed Polyamorous Multi-partnered

If divorced, please indicate date: _____
If widowed, please indicate date: _____
If remarried, please indicate # of times: _____

Do you live in: House Apartment Roommate Dorm
Other: _____

Description of Presenting Problem(s):
In your own words describe the nature of your main problems:

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Please estimate the severity of the problem(s) on the scale below:

Mild ____Moderate _____ Extreme _____ Severe _____Incapacitating _____

When did this problem begin? (Give dates):

_____

_____

_____

_____

Describe significant events occurring at the time, or since then, which may contribute to the development and/or maintenance of the problem(s):

_____

_____

_____

_____

Describe what solutions have been implemented and which have been most helpful:

_____

_____

_____

_____

Have you been in psychotherapy before(s)? If yes, please give dates and results:

_____

_____

_____

_____

Social & Personal History

Siblings: # of Brothers: _____ Ages of Brothers: _____

# of Sisters: _____ Ages of Sisters:_____

Mother: Living: Yes No If living, give age: _____

Deceased: Yes No If deceased; give age at time of death: _____

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Cause of Death: _____

Give your age at the time of death: _____

Occupation: _____

Education: _____

Father: Living: Yes No If living, give age: _____

Deceased: Yes No If deceased; give age at time of death: _____

Cause of Death: _____

Give your age at the time of death: _____

Occupation: _____

Education: _____

Step Parent: Living: Yes No If living, give age: _____

Deceased: Yes No If deceased, give age at time of death: _____

Cause of Death: _____

Give your age at the time of death: _____

Occupation: _____

Education: _____

1. How old were your parents when you were born?
2. Have you been told about your pregnancy experience?
3. Have you been told about your delivery?
4. Did you experience diaper rash as an infant/toddler?
5. Did you experience bed wetting?
6. Did you experience any trauma as a toddler/child?
7. Did your family travel around much during your childhood? (location/age)

Please describe family members who have a history of or are currently experiencing mental health concerns:

_____

_____

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Religion: As a child: _____
As an Adult: _____
Are you actively involved with a religious community? Yes No
Please describe your involvement (# days per week, level of involvement, titles):
_____
_____

Education: Indicate last grade completed and/or degree: _____

Summarize academic strengths and weaknesses:
Strengths:_____
_____
_____
Weakness_____
_____

Circle any of the following that applied to you during **childhood** and **adolescence**:

Happy	School Problems	Medical Problems	Family Problems
Unhappy	Emotional Problems	Legal Trouble	Alcohol Abuse
Drug Abuse	Behavioral Problems	Strong Religious Practices	

Other:
_____

Describe what sort of work you are doing now:
_____
_____

List what kind of jobs you have had in the past:
_____
_____

Do you find your present job satisfying? Yes No If No, please explain:
_____
_____

Do you have any financial concerns? Yes No If Yes, please explain:
_____
_____

Describe your past ambitions:
_____
_____

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Describe your current ambitions:

_____

_____

Feelings

Underline any of the following feelings that currently apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy
Bored	Sad	Conflicted	Restless	Depressed
Regretful	Lonely	Anxious	Hopeless	Contented
Fearful	Excited	Hopeful	Panicky	Helpless
Optimistic	Energetic	Relaxed	Tense	Envy
Jealous	Motivated	Down	Sexy	Alone

Other: _____

Please list FIVE current fears:

1. _____
2. _____
3. _____
4. _____
5. _____

What feelings would you like to experience more often:

_____

_____

What feelings would you like to experience less often:

_____

_____

What are some positive feelings you have experienced recently?

_____

_____

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When are you most likely to lose control of your feelings?

_____

_____

Describe any situations that make you feel calm and/or relaxed:

_____

_____

Please complete the following statements:

If I told you what I am feeling now I would say _____.

One of the things I feel proud of is _____.

One of the things I feel guilty about is _____.

I am most happy when _____.

I am sad when _____.

I get angry when _____.

List what kind of hobbies/leisure activities you enjoy and/or find relaxing:

_____

_____

Do you have trouble enjoying weekends and/or vacations? Yes No If YES, please explain:

_____

_____

Thoughts

Underline each of the following **thoughts** that apply to you:

I am worthless, a nobody, useless and/or unlovable.

I am unattractive, incompetent, stupid and/or undesirable

I am evil, crazy, degenerate and/or deviant

Life is empty, a waste; there is nothing to look forward to.

I make too many mistakes, can't do anything right.

Underline each of the words below that you might use to describe yourself:

Intelligent	Indecisive	Sensitive	Worthless	Considerate
Deviant	Unattractive	Honest	Compassionate	Inadequate

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Loyal	Good	Confused	Ugly	Confident
Funny	Trustworthy	Crazy	Regretful	Naïve
Attractive	Resilient	Unlovable	Stupid	Ethical
Hard Working	Ambitious	Motivated	Incompetent	Lonely

What do you consider to be your most irrational thought?

_____

_____

Are you bothered by thoughts that occur over and over again? Yes No Sometimes

Explain:

_____

_____

On the items below please indicate your choice that most accurately reflects your opinions:

Strongly Disagree = SD Disagree=D Neutral=N

Agree=A Strongly Agree=SA

____ I should not make mistakes. _____ I should be good at everything.

____When I do not know something I should pretend that I do.

____I should not disclose personal information. ____ I am a victim of circumstance.

____My life is controlled by outside forces. ____I play it safe and do not take risks.

____ Other people are happier than I am. ____ I do not deserve to be happy.

____ It is very important to me to please others. ____ I strive for perfection.

____If I ignore my problems they will disappear. ___ There is only right and wrong.

____ I am responsible for other's happiness. _____ I must be nice at all times.

Biological Factors

Please specify any current health concerns:

_____

_____

Please list current medications below (including over the counter and herbal medications) and the length of time you have been taking them:

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Please indicate the reason for your last visit to a doctor and the date:

Please indicate the date of your last physical/check up/annual exam:

Have you ever been hospitalized? Yes No If YES, please explain:

_____

_____

Please list any surgeries you may have had or that are scheduled for the future:

Do you eat three meals a day? Yes No If NO, please describe your eating habits:

_____

_____

Has your diet changed in the past 3 months? Yes No

Have you experienced weight loss or weight gain in the past 3 months? Yes No

Please indicate change: _____

Do you exercise? Yes No If YES, please complete the information below:

# of days per week: _____

Exercise in the form of:

_____

Have your sleep habits changed within the last 3 months? Yes No If YES, see below:

Do you have trouble going to sleep? Yes No

Are you taking medication to help with sleep? Yes No

Medication: _____

Do you have trouble staying asleep? Yes No

Do you experience dreams? Yes No

Do your dreams wake you up? Yes No

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Please list any pertinent family health history below:

Are you a smoker? Yes No If YES, how much do you smoke a day? _____

Do you drink alcohol? Yes No If YES, please indicate the amount and type of alcohol used within **one** week: Beer _____ Wine_____ Liquor_____

Other: _____

Do you use drugs? Yes No

Do you have a history of smoking, alcohol, and/or drug abuse? Yes No

If YES, please explain:

_____

_____

Relationships

Do you make friends easy? Yes No

Do you have long-term friendships? Yes No

Were you ever bullied or teased? Yes No If YES, how old were you? ____

List relationships that currently bring you:

Joy:

Grief:

Indicate below how you feel in NEW social situations:

____ Very relaxed _____Relatively Comfortable _____ Somewhat Uncomfortable _____Anxious

Describe below how you express your feelings, opinions, wishes, and desires to others:

Describe individuals with whom you have trouble asserting yourself:

Did you date in High School? College?

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Do you have one or more friends you feel comfortable sharing your most private thoughts and feelings with?

If you are in a long-term relationship or married please indicate below how long you knew your spouse or significant other prior to your engagement or cohabitation:

How long have you been with the person indicated above?

_____

How old is your partner? _____

If you are currently single describe below previous long-term relationships (duration, age of other):

Describe the personality of your partner:

List areas where you and your partner are/were compatible:

List areas where you and your partner are/were incompatible:

Do you have children and/or stepchildren? Yes No

If YES, below list age, relation (step, biological, adopted, foster) and sex:

Describe your relationship with the children:

Sexual Development & History

Define what intimacy is for you:

Define what sexuality is for you:

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Described your first sexual experience (please indicate your age/sexual act/age of other/sex of other):

List the person(s) and/or place(s) where you learned about sex:

_____ _____

_____ _____

_____ _____

Do you currently engage in sexual fantasy? Yes No

Do you currently self stimulate (masturbate)? Yes No

List FIVE forms of sexual expression in your life:

1. _____
2. _____
3. _____
4. _____
5. _____

Of the five forms listed above which is:

Most Favorite: # _____ Least Favorite #_____

Are you satisfied with the frequency of sexual activity? Yes No
Are you satisfied with your sexual function? Yes No

If you are in a sexual relationship how often do you and your partner discuss the relationships sexual health?
Weekly____Monthly___ Every 3 months ____ Rarely/Never____Other_____

If you are unhappy or in some ways dissatisfied with your current sexual life please indicate concerns in the list below:

1. _____ little or no interest and/or desire in sex
2. _____ decreased genital sensation/erection
3. _____ decreased lubrication
4. _____ orgasm/ejaculation

5. _____ pain during/after/prior to sex
6. _____Other: _____

Which problem described above would you consider to be most bothersome? (Circle)

1 2 3 4 5 6

Have you spoken with a professional about your concerns? Yes No

If YES, what kind of professional? _____

Expectations regarding psychotherapy

In your own words, summarize what you think therapy is all about:

How long do you think therapy should last?

How do you think a therapist should interact?

What personal qualities do you think the 'ideal' therapist should possess?

Describe your goals for therapy below: