**Life History Questionnaire**

**Please mark all of the following that apply**

**Feelings**

[ ]  **Helplessness** [ ]  **Anxious** [ ]  **Depressed** [ ]  **Out of control** [ ]  **Shameful** [ ]  **Afraid** [ ]  **Angry**

[ ]  **Numb** [ ]  **Guilty** [ ]  **Relaxed** [ ]  **Hopeless** [ ]  **Happy** [ ]  **Lonely** [ ]  **Excited** [ ]  **Sad** [ ]  **Hopeful**

[ ]  **Stressed** [ ]  **Inferiority Feeling** [ ]  **Unhappy** [ ]  **Mood shifts** [ ]  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thoughts**

[ ]  **Confused** [ ]  **Racing** [ ]  **Unintelligent** [ ]  **Obsessive** [ ]  **Worthless** [ ]  **Distracted**

[ ]  **Unmotivated** [ ]  **Disorganized** [ ]  **Unattractive** [ ]  **Paranoid** [ ]  **Unlovable** [ ]  **Suicidal**

[ ]  **Confident** [ ]  **Sensitive** [ ]  **Worthwhile** [ ]  **Honest** [ ]  **Homicidal** [ ]  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptoms/ Behaviors**

[ ]  **Eating less**[ ]  **Acting out Sexually** [ ]  **Socializing** [ ]  **Procrastinating** [ ]  **Acting Aggressively**

[ ]  **Marital Relationships** [ ]  **Attempting Suicide** [ ]  **Disorganization** [ ]  **Parent/Child Conflicts**

[ ]  **Poor Concentration** [ ]  **Impulsivity** [ ]  **Lack of Ambition/Goals** [ ]  **Crying** [ ]  **Recklessness**

[ ]  **Poor Peer Relationships** [ ]  **Withdrawing Socially** [ ]  **Irritability** [ ]  **Nightmares** [ ]  **Skipping Classes** [ ]  **Passivity** [ ]  **Worries about body image** [ ]  **Binge Drinking** [ ]  **Drug use** [ ]  **Spiritual Problems**

[ ]  **Self Harm** [ ]  **Alcohol Use** [ ]  **Dating Concerns** [ ]  **Compulsivity** [ ]  **Being good to yourself**

[ ]  **Finances** [ ]  **Career/Major Choice** [ ]  **Sexual Problems** [ ]  **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Symptoms**

[ ]  **Insomnia** [ ]  **Tired** [ ]  **Weight Gain/Loss** [ ]  **Pain** [ ]  **Headaches** [ ]  **Tightness In Chest**

[ ]  **Dizziness/Light-headedness** [ ]  **Numbness/tingling** [ ]  **Vomiting** [ ]  **Rapid Heartbeat**

[ ] **Dry Mouth** [ ]  **Excessive Sleep** [ ]  **Loss of memory** [ ]  **Eating Problems** [ ]  **Other \_\_\_\_\_\_\_\_\_\_**

**Please describe and medical conditions you may have or medications that you are on:**