**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:**