

Center For Renewing Intimacywww.renewingintimacy.com

6270 Lehman Drive, Suite 200G

Colorado Springs CO 80918

(719) 331-6484

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 Center For Renewing Intimacy 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 - - | | |

| |
|-------|
| Email |
|-------|

| | | | | | |
|--|---------------------------------|---------------------------------|---------------------------------|------------------------------------|--------------------------------|
| 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? Was it reported <input type="checkbox"/> No <input type="checkbox"/> Yes When |
| <input type="checkbox"/> Have you ever been emotionally abused? | |

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)?

2. How motivated are you to resolve your concern(s)?

3. How optimistic are you that your concern(s) can be resolved?

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

Feelings / Thoughts

Helpless

Anxious

Confused

Agitated

Depressed

Out of Control

Unintelligent

Obsessive

Shameful

Fearful

Worthless

Distracted

Angry

Emotionally Numb

Unmotivated

Disorganized

Guilty

Bored

Suicidal

Paranoid

Hopeless

Confident

Panicky

Unloved

Lonely

Unattractive

Useless

Sensitive

Happy

Aggressive

Worthwhile

Rageful

Stressed

Inferior

Homicidal

Self-Conscious

Loved

Responsive

Moody

Low Self-esteem

Symptoms / Behaviors

Hallucinations

Acting Out Sexually

Same Sex Attraction

Procrastinating

Acting Aggressively

Marital Conflict

Poor Concentration

Disorganization

Parent/Child Conflicts

Withdrawing Socially

Impulsivity

Lack of Ambition/Goals

Decreased Energy

Recklessness

Poor Peer Relationships

Excessive caffeine/sugar

Irritability

Nightmares

Financial Problems

Passivity

Worries About Body Image

Injuring self

Tobacco Use #per day

Spiritual Problems

Career Problems

Compulsivity

Dating or Relational Concerns

Lustful thoughts

Drug Use

Excessive Internet or TV Use

Masturbation

Sexual Dysfunction(s)

Gambling/Gaming

Pornography

Alcohol Use # per day

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