



# SEASONS IN OUR LIFE

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## **LIFE HISTORY QUESTIONNAIRE**

### **Purpose:**

The purpose of this questionnaire is to get a complete picture of your life history and family background. In therapy, we are concerned with issues that impact on you, your relationships, and your family from many sources. Among those sources are (a) your family of origin, that is your parents and grandparents; (b) your physical health; (c) your life history; and (d) things that are influencing you right now. By asking you about these things in questionnaire form, we can save a great deal of valuable therapy interview time. Therefore, answering these routine questions as fully and as accurately as you can will make it possible for us to get to work on the things that concern you much more quickly.

All case records are strictly confidential. NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR PERMISSION IN WRITING.

If you have any questions about this questionnaire, please feel free to ask at any time. If you do not wish to answer a question, you may write "I do not wish to answer."

DATE \_\_\_\_\_

### **General Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Children's Names: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers: (days) \_\_\_\_\_ (evenings) \_\_\_\_\_



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Your Occupation: \_\_\_\_\_

Partner's Occupation: \_\_\_\_\_

Current Relationship Status (check one)

☐ Single    ☐ Engaged    ☐ Married    ☐ Separated    ☐ Divorced    ☐ Widowed

Remarried:    ☐ Yes ☐ No      How many times? \_\_\_\_\_

What is/are the issue(s) or problem(s)? Please describe:



On the scale below, please indicate how upsetting your problem(s) is/are right now:

mildly upsetting \_\_\_\_\_ moderately upsetting \_\_\_\_\_ very upsetting \_\_\_\_\_

extremely upsetting \_\_\_\_\_ totally upsetting \_\_\_\_\_

When did your problem(s) begin (describe and give dates)?

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Please describe any important event occurring at that time or since then that may have started the problem(s) or which keep them going:

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What do you believe causes or contributes to the maintenance of your problem(s), for example, stresses, emotional reactions, diet, etc.?



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What solutions to your problems have you found helpful?

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Have you received any prior professional assistance for your problem? If so, give name(s), professional title(s), date(s) of treatment(s), and results:

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## Family of Origin History:

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Siblings:

Number of brothers: \_\_\_\_\_

Brothers' ages: \_\_\_\_\_

Number of sisters: \_\_\_\_\_

Sisters' ages: \_\_\_\_\_

Father: Living? \_\_\_\_\_ If alive, give father's age: \_\_\_\_\_

Deceased? \_\_\_\_\_ If deceased, give father's age at time of death: \_\_\_\_\_

How old were you at the time? \_\_\_\_\_ Cause of death: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health: \_\_\_\_\_

Does or did your father have (check all that apply):

☐ Drinking problem

☐ Drug problem

☐ Depression

☐ Depression with highs and lows

☐ Mental Illness

Mother: Living? \_\_\_\_\_ If alive, give mother's age: \_\_\_\_\_

Deceased? \_\_\_\_\_ If deceased, give mother's age at time of death: \_\_\_\_\_

How old were you at the time? \_\_\_\_\_ Cause of death: \_\_\_\_\_

Occupation: \_\_\_\_\_



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Health: \_\_\_\_\_

Does or did your mother have (check all that apply):

- ☐ Drinking problem
- ☐ Drug problem
- ☐ Depression
- ☐ Depression with highs and lows
- ☐ Mental Illness

Did or does any other member of your family have problems with (check all that apply):

- ☐ Drugs      ☐ Alcohol      ☐ Depression
- ☐ Diabetes      ☐ Mental Illness      ☐ Epilepsy

If so, state who: \_\_\_\_\_

Your religion: As a child: \_\_\_\_\_ As an adult: \_\_\_\_\_

Your education: What is the last grade completed? \_\_\_\_\_

Do you have a degree? Please list: \_\_\_\_\_

Check any of the following that applied during your childhood or adolescence:

- ☐ Happy Childhood      ☐ Unhappy Childhood
- ☐ Emotional Problems      ☐ Drug Abuse
- ☐ Eating Disorder      ☐ School Problems
- ☐ Family Problems      ☐ Behavior Problems
- ☐ Physical Abuse      ☐ Medical Problems
- ☐ Alcohol Abuse      ☐ Sexual Abuse
- ☐ Legal Trouble      ☐ Other Problems: \_\_\_\_\_

If you were not brought up by your parents, who raised you and between what years?

\_\_\_\_\_



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Give a description of your father's (or father substitute's) personality and his methods of discipline (past and present):

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How did your father show affection, and how often did he share affection with you? With others in the family? (past and present):

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Give a description of your mother's (or mother substitute's) personality and her methods of discipline (past and present):



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How did your mother show affection, and how often did she share affection with you? With others in the family? (past and present):

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What specific methods did your father (or father substitute) use to control you and other members of the family?

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What specific methods did your mother (or mother substitute) use to control you and other members of the family?



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What did your father do to control the expression of affection in the family?

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What did your mother do to control the expression of affection in the family?

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What were the prevailing emotional overtones in your family when you were growing up?

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Has any relative attempted or committed suicide?

☐ Yes ☐ No

Has any relative had serious problems with the law?

☐ Yes ☐ No

## **Your Personal History:**

What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ inches

What is your weight? \_\_\_\_\_ pounds

Do you now have or have you ever had (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Alcohol problems              | <input type="checkbox"/> Drug problems |
| <input type="checkbox"/> Unusual physical problems     |  |
| <input type="checkbox"/> Strange or unusual sensations |  |



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Other Illnesses:

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Have you ever been hospitalized for psychological problems? ☐ Yes ☐ No

If Yes, when and where?

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Do you have a family physician? ☐ Yes ☐ No

If so, please give his/her name and telephone number:

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Have you ever attempted suicide? ☐ Yes ☐ No

What is your current health:

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What kinds of jobs have you held in the past?

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What sort of work are you doing now?

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Does your present work satisfy you? ☐ Yes ☐ No

If no, please explain:

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What is your annual family income? \$ \_\_\_\_\_

How much does it cost you to live? \$ \_\_\_\_\_

What were your past ambitions?

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What are your current ambitions?

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Check any of the following behaviors that apply to you:

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|--|--|---|
| <input type="checkbox"/> Overeat             | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Concentration difficulties |
| <input type="checkbox"/> Take drugs          | <input type="checkbox"/> Lazy                | <input type="checkbox"/> Withdrawal                 |
| <input type="checkbox"/> Odd behavior        | <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Sleep disturbance          |
| <input type="checkbox"/> Smoke               | <input type="checkbox"/> Loss of control     | <input type="checkbox"/> Can't keep a job           |
| <input type="checkbox"/> Crying              | <input type="checkbox"/> Procrastination     | <input type="checkbox"/> Take too many risks        |
| <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Drink too much      | <input type="checkbox"/> Eating problems            |
| <input type="checkbox"/> Phobic avoidance    | <input type="checkbox"/> Work too hard       | <input type="checkbox"/> Impulsive behaviors        |
| <input type="checkbox"/> Nervous tic         | <input type="checkbox"/> Suicidal attempts   |   |
| <input type="checkbox"/> Outbursts of temper | <input type="checkbox"/> Compulsion          |   |

What kinds of hobbies or leisure activities do you enjoy or find relaxing?

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## Menstrual History:

Age at first period: \_\_\_\_\_

Were you informed or did it come as a shock?

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Are your periods regular? ☐ Yes ☐ No

Do you have pain? ☐ Yes ☐ No

Does your period affect your mood? ☐ Yes ☐ No



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## **Your Current Family/Your Family of Procreation Relationship:**

How long have you known your partner? \_\_\_\_\_

If married, how long did you know your partner before your engagement?

\_\_\_\_\_

How long were you engaged? \_\_\_\_\_

How long have you been married? \_\_\_\_\_

## **Sexual Relationships:**

Describe your parents' attitude toward sex:

\_\_\_\_\_

\_\_\_\_\_

Was sex discussed in your home? ☐ Yes ☐ No

When and how did you derive your first sexual knowledge?

\_\_\_\_\_

\_\_\_\_\_

When did you first become aware of your own sexual impulses?

\_\_\_\_\_

\_\_\_\_\_

Have you ever experienced any anxiety or guilty feelings arising out of sex or masturbation?

☐ Yes ☐ No

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Any relevant details regarding your first or subsequent sexual experiences?

\_\_\_\_\_

\_\_\_\_\_

Is your present sex life satisfactory? ☐ Yes ☐ No

If not, please explain:



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Provide information about any significant homosexual reactions or relationships:

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Please note any sexual concerns not discussed above:

**Children and Family:**

Give a description of your methods of discipline (past and present):

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How do you show affection, and how often do you share affection with your partner?

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With others in the family? (past and present):

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Give a description of your partner's methods of discipline (past and present):

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How does your partner show affection, and how often does he/she share affection with you?

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With others in the family? (past and present):



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What specific methods do you use to control other members of the family?

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What specific methods does your partner use to control you and other members of the family?

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What do you do to control the expression of affection in the family?

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What does your partner do to control the expression of affection in the family?

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What are the prevailing emotional overtones in your family?

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Do any of your children present special problems?

## **Stress:**

Check any of the following which apply and indicate the family member involved such as partner, child, father, mother, brother, sister, yourself and so on:

### **Event**

### **Family Member(s) Involved**

☐ Death in the family

☐ Divorce



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- ☐ Trouble with the law
- ☐ Financial trouble
- ☐ Job/School
- ☐ Serious illness
- ☐ Serious operation
- ☐ Mental illness
- ☐ Alcohol
- ☐ Drugs
- ☐ Interpersonal problems
- ☐ Sexual abuse
- ☐ Depression
- ☐ Physical abuse
- ☐ Suicide
- ☐ Other: \_\_\_\_\_

## **Systems Outside of Your Family:**

How do you get along with your in-laws, including brothers and sisters-in-law?

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Have your parents, brothers, or sisters ever interfered in your relationship?

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Are you having any trouble on the job or in school?

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Have your parents, relatives or friends interfered in your job or school?



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Has your Bishop, Priest or Clergy made a special effort to talk to you about your behavior or the behavior of a member of your family?

☐ Yes ☐ No

Have the police or other social agencies interfered in your family? ☐ Yes ☐ No

Have there been any other outside disturbances to your family? ☐ Yes ☐ No

## **Friendships:**

Do you make friends easily? ☐ Yes ☐ No

Do you keep them? ☐ Yes ☐ No

Rate the degree to which you generally feel comfortable and relaxed in social situations:

☐ Very relaxed

☐ Relatively comfortable

☐ Relatively uncomfortable (crowds)

☐ Very anxious

## **Expectations regarding therapy:**

In a few words, what do you think therapy is all about?

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How long do you think therapy should last?

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How do you think a therapist should interact with his/her clients?

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

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