

Life, Family and Relationship Questionnaire

Date _____

The purpose of this questionnaire is to help advance the therapy process by providing information about your life's journey to this point. In marriage and family therapy we are concerned with issues that impact you, your health, your family of birth, your committed relationships, your children and your work. By asking these things in questionnaire form, we can save a great deal of valuable therapy interview time. Therefore by answering these routine questions as fully and accurately as you can, it will make it possible for us to get to work on the issues that concern you the most more quickly.

All responses are strictly confidential and will not be released without your written permission. If you have any questions about this questionnaire, please feel free to call.

Name: _____ Birthdate: _____ Age: _____

Single Living together Engaged Married Separated Divorced Widowed

Spouse's Name (if married): _____ Age: _____

Date of Marriage: _____ Length of Engagement: _____ Years Dating: _____

Previously Married: Yes No (if yes, how many times? _____)

Spouse Previously Married: Yes No (if yes, how many times? _____)

Children's Names: (Include and identify step-children)

_____ Sex: Age: _____ Grade: _____ Married:

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_____ Sex: Age: _____ Grade: _____ Married:

_____ Sex: Age: _____ Grade: _____ Married:

Reason for Seeking Therapy

My reason(s) for seeking therapy is/are: _____

What solutions to your problem(s) have you found helpful? _____

When did the problem(s) begin? (Date) _____

Other personal concerns I have include:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Feeling Blue | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Feeling Angry | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Family tension/conflict | <input type="checkbox"/> Parenting concern | <input type="checkbox"/> Financial stress | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Religious differences | <input type="checkbox"/> Addiction concerns | <input type="checkbox"/> Tired | <input type="checkbox"/> Work stress |
| <input type="checkbox"/> Infidelity Concerns | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Lack of trust | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Communication Issues | <input type="checkbox"/> Custody/visitation Problems | | _____ |

Health

Do you have any physical symptoms that concern you? _____

List any medication you are taking: _____

Family Doctor: _____ Date of last physical: _____

History of Medical Condition: _____

Do you exercise? ___ Yes ___ No (if yes, how and how often?) _____

Do you: (check all that apply) ___ drink alcohol ___ use drugs ___ smoke ___ drink caffeine
 ___ want to (Gain/Lose) weight ___ have high blood pressure
 ___ have allergies ___ have trouble sleeping

Briefly describe your overall health? _____

Have you ever felt you should **Cut** down on your drinking? Yes No
 Have people **Annoyed** you by criticizing your drinking? Yes No
 Have you ever felt bad or **Guilty** about your drinking? Yes No
 Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye Opener**)? Yes No

Source: Ewing JA. Detecting alcoholism: the CAGE questionnaire. JAMA 1984;252:1905-1907. CAGE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure, or have let yourself or family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things such as reading the newspaper or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thought that you would be better off dead, or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Family of Origin History

Father's Name: _____ Living? Yes No (If yes) Age: _____

Occupation: _____ Health: _____

If Deceased – His age at death: _____ Cause of Death: _____

Your age at his Death: _____ Describe Relationship: _____

Mother's Name: _____ Living? Yes No (if yes) Age: _____

Occupation: _____ Health: _____

If Deceased – Her age at death: _____ Cause of Death: _____

Your age at her Death: _____ Describe Relationship: _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Describe your father's father: _____

Describe your father's mother: _____

Describe your mother's father: _____

Describe your mother's mother: _____

Check any of the following that applied in your family during your youth:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce | <input type="checkbox"/> Affairs |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Verbal Abuse | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> School Problems | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Medical Illness |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Death | <input type="checkbox"/> Suicide | <input type="checkbox"/> Legal Troubles |

How did your family express care and affection: _____

How did your family express anger and manage conflict: _____

How did your family manage anxiety and stress: _____

Religious / Spiritual

I consider myself a spiritual person? ___ Yes ___ No ___ Uncertain

My religious preference is:

- | | |
|--|--------------|
| ___ Protestant (Denomination) _____ | ___ Jewish |
| ___ Agnostic (not sure about existence of God) | ___ Catholic |
| ___ Atheist (do not believe in the existence of God) | ___ Orthodox |
| ___ Other: Please specify _____ | ___ None |

Do you pray? ___ Yes ___ No ___ Occasionally

Do you meditate? ___ Yes ___ No ___ Occasionally

Do you read the Bible? ___ Yes ___ No ___ Occasionally

How often do you attend a place of worship? _____

How important are matters of faith in your life? _____

In what church / faith tradition were you raised? _____

Employment

Occupation: _____ Employer: _____

Retired (Date): _____ Unemployed (Date): _____

Spouse's Occupation: _____ Employer: _____

Rate your job satisfaction: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What do you enjoy about your job? _____

What do you dislike about your job? _____

Therapy

Have you had previous experience with counseling? ___ Yes ___ No

If yes, when: _____ Therapist: _____

When: _____ Therapist: _____

For you, therapy will be successful when: _____

The likelihood that therapy will succeed is: ___ Very Good ___ Good ___ Poor ___ Very Poor

I expect it will take _____ sessions to complete my therapy goals.