Catherine A. Gourley, Ph.D.

Licensed Psychologist
License #32050
Email: DrCAGourley@austin.rr.com
Website: www.drgourley.com

3705 Medical Parkway, Ste. 360
Austin, Texas 78705
512-452-3392, ext. 3
Fax: 512-452-3393

1010 Ranch Road 620 S., Ste. 203
Lakeway, Texas 78734
512-452-3392, ext. 3
Fax: 512-452-3393

Life History Form

PURPOSE: The background information you provide me here can help me immeasurably as I work with you. It can also help to speed up the process, since you can do this relatively quickly on your own time rather than providing me with the same information a little bit at a time. As is the case with all we do, the information you give me here will be used only in accordance with the limitations of confidentiality we have already discussed. **Please leave blank any question you would rather not answer.**

COMPLETING THE FORM:
The Life History Form is a pdf form. You may either (1) Print the document and fill it out by hand or (2) Fill out the form on your own computer and then print the document. To fill in the form on your own computer, you will need the latest version of Adobe Reader.

SUBMITTING THE FORM:
Please DO NOT SEND the completed Life History form to me by email, as it is not a secure medium. If you wish, you may send the completed form by US Mail to: 3705 Medical Parkway, Suite 360, Austin, Texas 78705 OR FAX it to: 512-452-3393.

CURRENT LIVING ARRANGEMENT:

Please check your living arrangement: _____ House _____ Room _____ Apartment _____ Other

With whom are you now living, and how are you related to them?

____

Are there any problems with your current living arrangement (describe)?

____

RELATIONSHIP HISTORY:

(Please answer these questions with respect to current and past marriages/significant relationships)

What is your current (romantic) relationship status? ________________________________

How long did you know your partner/ex-partner before making the commitment?

____

What is/was your partner's date of birth? ______________________ Occupation? ____________________________

In what ways are/were you compatible? ____

____

In what ways are/were you incompatible? ____

____

How satisfactory is/was your relationship(s) ____

____

How do/did you get along with your partner's relatives? ____

____

Do you have children? _____ Yes _____ No   Or do you plan to have children? _____ Yes _____ No

How many children do you have _____ or plan to have? _____

Were your current children planned _____ Yes _____ No

Please briefly describe any children involved in your relationship: ____

____

How do you feel about your skills as a parent, and about your partner's skills in that area?

____

____

Who are the most important people in your life? ____

____

Do you make friends easily? ____

Do you keep friends once you have made them? ____

With whom are you likely to share your deepest feelings? ____

____

____

FAMILY OF ORIGIN

Please describe your father in terms of his age, psychological or physical strengths and problems, his attitude toward you when you were a child and later, and his attitude toward your mother and any siblings. If he is dead, please indicate his age and your age at the time of his death.

____

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Please describe your mother in terms of her age, psychological or physical strengths and problems, her attitude toward you when you were a child and later, and her attitude toward your father and any siblings. If she is dead, please indicate her age and your age at the time of her death.

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Please also describe the course of your parents' relationship. That is, were they married at the time of your birth, did their marriage last until one of them died, did they divorce, are they still married, etc.

____

____

____

____

If you had one or more step-parents, please discuss them in terms similar to those suggested above for your parents.

____

____

____

____

What are the drinking and substance use habits in your family of origin? ____________________

____

____

What was it like to grow up in your home? ______________________________________

____

____

____

Were you able to confide in your parents? ______________________________________

What forms of reward and punishment do you recall from your childhood? __________________

____

____

____

____

HEALTH:

How would you describe your physical health? ____

List any physical limitations. ____

____

Please list any health problems. ____

____

Please check any of the following that apply to you:

_____ Numbness	_____ Tingling	_____ Bowel problems
_____ Difficulty relaxing	_____ Sexual disturbances	_____ Tension
_____ Muscle spasms	_____ Palpitations	_____ Dizziness
_____ Headaches	_____ Stomach trouble	_____ Tics
_____ Fatigue	_____ Twitches	_____ Back pain
_____ Tremors	_____ Fainting spells	_____ Hear things
_____ Watery eyes	_____ Flushes	_____ Skin problems
_____ Dry mouth	_____ Burning/itchy skin	_____ Chest pains
_____ Rapid heart beat	_____ Don't like being touched	_____ Blackouts
_____ Excessive sweating	_____ Visual disturbances	_____ Hearing problems

Are you using any prescription medications? If so, which ones?

____

____

Any non-prescription medications? ____

Do you use drugs? (If so, state the substances & frequency of use.) ______________________

____

Do you consume alcohol? (If so, how frequently?) ______________________________

____

Do you ever binge-eat? ____________________ Do you ever purge? ____________________

Please describe your typical sleep habits and patterns.

____

When were you last examined by a physician? ______________________________

In what forms of physical exercise do you regularly engage?

____

The Questions in Italics Are for Female Clients:

Age of first period: ____________________ *Prepared or a shock?* ______________________________

Any menstrual problems? ______________________________

Do your periods affect your moods or cause any physical changes or other problems? (If yes, please elaborate)
____

____

____

Number of pregnancies: __________________ *Miscarriages:* ______________________________

Abortions: ____________________________ *Contraception used:* ____________________________

SEXUALITY:

What were your parent's attitudes toward sex? ____

____

____

At what age and how did you derive your first knowledge of sex? ____________________________________

____

____

Are you satisfied with your sexuality and with your sexual relationships? ___________________________

____

____

____

Do you have any sexual problems now? If so, please elaborate. ____________________________________

____

____

LIFE EXPERIENCES:

What people, events, habits, books or other influences have been most helpful in your life?

____

____

____

What are some of the best times you can recall? ______________________

____

What are some of the most difficult times you have faced? ______________________

____

____

What makes you feel anxious or frightened now? ______________________

____

____

What most helps you feel calm, relaxed and secure? ______________________

____

____

What goals do you have for yourself in life? ______________________

____

What do you with leisure time? ______________________

____

What roles have spirituality and religion played in your life? ______________________

____

____

____

PAST COUNSELING OR THERAPY

Please describe any past experiences with counseling, psychotherapy, hospitalizations for psychological problems, etc. and provide name(s), professional title(s), dates of treatments and results:

What were you working on?

Do you feel you benefited from this experience? If not, why?

Why did it end?

Have you ever thought about hurting yourself or made a suicide attempt? If so, please describe.

CURRENT SITUATION

Describe the nature of you main problems.

When did these problems begin (give dates)

Please indicate the severity of your problem(s):

_____ Mildly upsetting
_____ Moderately upsetting
_____ Severe
_____ Extremely severe
_____ Totally incapacitating

Please describe significant events that may relate to the development, or maintenance of your problems:

____

____

____

What solutions have been helpful for your problems? ____

____

____

____

Check any of the following behaviors that apply to you:

_____ Overeat
_____ Take drugs
_____ Vomiting
_____ Odd behavior
_____ Work too hard
_____ Drink too much
_____ Procrastination
_____ Crying
_____ Loss of control
_____ Suicide attempts
_____ Compulsions
_____ Smoking
_____ Withdrawal
_____ Concentration problems
_____ Nervous tics
_____ Impulsive reactions
_____ Phobic avoidance
_____ Can't keep a job
_____ Insomnia
_____ Take too many risks
_____ Lazy
_____ Aggressive behavior
_____ Eating problems
_____ Sleep disturbance
_____ Outbursts of temper

What are some special talents or skills you feel proud of? ____

____

____

____

What would you like to do more of? ____

What would you like to start doing? ____

What would you like to stop doing? ____

____

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities?

____

Do you practice relaxation or meditation regularly? _______________________________________

Please check any of the following feelings that often apply to you:

____ Angry	____ Guilty	____ Unhappy
____ Annoyed	____ Happy	____ Bored
____ Sad	____ Conflicted	____ Restless
____ Depressed	____ Regretful	____ Lonely
____ Anxious	____ Hopeless	____ Contented
____ Fearful	____ Hopeful	____ Excited
____ Panicky	____ Helpless	____ Optimistic
____ Energetic	____ Relaxed	____ Tense
____ Envy	____ Jealous	____ Others:
		________________________

List your four main fears:

1. ____

2. ____

3. ____

4. ____

What do you hope to gain from psychotherapy? ____

____

____

Name ____ Date of Birth ____________________

Address __________________________________ City & Zip Code _______________________

Telephone _________________________ Cell Phone _________________________________

Social Security Number __________________________________

Email ____