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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.**

CURRENT LIVING ARRANGEMENT:

Please circle 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?

How does/did your partner(s) get along with your relatives?

Do you have children? _____ or do you plan to have children? _____

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

Were your current children planned?

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.

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.

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?

Please list any physical limitations.

Please list any health problems.

Please circle 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 or itch 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 at 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 parents' 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 to you 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 most anxious or frightened now?

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

What goals do you have for yourself in life?

What do you do 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:

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What were you working on?

Did 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 your main problems

Please estimate the severity of your problem(s):

Mildly Upsetting Moderately Upsetting Severe

Extremely Severe Totally Incapacitating

When did these problems begin (give dates):

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

What solutions have been helpful for your problems?

Circle any of the following behaviors that apply to you:

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

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? _____

Circle 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 _____

Address _____

City & Zip Code _____

Telephone Number _____ Date of Birth _____

Cell Phone _____

Social Security Number _____

Email: _____