WHITWORTH UNIVERSITY

MARRIAGE & FAMILY THERAPY CENTER

Couple, Marital & Family Life History Questionnaire

(to be completed by client)

Purpose: *The purpose of this questionnaire is to get a complete picture of your couple, marital and family background. In marriage and family therapy, we are concerned with issues that influence you, your marriage, and your family from many sources. Among those sources are (a) your family of origin (i.e. your parents and grandparents); (b) your physical health; (c) your life history; (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 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 confidential. Except where legally mandated, these records will be seen by no one without your written permission. 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."

Name: _____ Today's Date: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) - _____- _____ Alternate Phone: (_____) - _____- _____

Email: _____ Alternate Email: _____

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Employer Information

Employer: _____

Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Partner Information

Name of spouse/partner: _____

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Address (if different): _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) - _____- _____ Alternate Phone: (_____) - _____- _____

Email: _____ Alternate Email: _____

Employer: _____

Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Relationship Status

❑ Single (never married)
❑ Separated
❑ Remarried (after spouse's death)
❑ Remarried (after divorce)
❑ First marriage
❑ Cohabitating (living together)
❑ Widowed
❑ Significant other
❑ Divorced
❑ Other: _____

If in a relationship, length of relationship: _____

Children

Please list: name, sex, age, type (biological, step, etc.) Do you have custody? ❑ Yes ❑ No

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Description of Presenting Problems:

Please state in your own words the nature of your concerns.

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

❑ Mildly upsetting ❑ Moderately upsetting ❑ Very upsetting ❑ Totally upsetting ❑ Extremely upsetting

When did your problem(s) begin? (Include dates if possible):

Please describe any important events that occurred at that time, or since then, that may have started the problem(s) or that contribute to the problem(s) continuation:

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

Have you been in therapy before, or have you received any prior professional assistance for your problem(s)?

If so, please include names, professional titles, dates of treatment, and results.

Family of Origin History

Date of Birth: _____ Place of Birth: _____

Number of brothers and their ages:

_____

_____

_____

Number of sisters and their ages:

_____

_____

_____

Father's Health & History

Is your father living? ❑ Yes ❑ No *If alive,* father's age: _____

Father's health:

_____

_____

If deceased, father's age at time of death: _____ How old were you at the time? _____

Cause of death:

_____

_____

Occupation: _____

Does or did your father have any of the following conditions? *(Check all that apply.)*

❑ Drinking problem ❑ Depression ❑ Depression with highs and lows ❑ Drug problem ❑ Mental illness

Mother's Health & History

Is your mother living? ❑ Yes ❑ No *If alive,* mother's age: _____

Mother's health:

_____

_____

If deceased, mother's age at time of death: _____ How old were you at the time? _____

Cause of death:

_____

_____

Occupation: _____

Does or did your mother have any of the following conditions? *(Check all that apply.)*

❑ Drinking problem ❑ Depression ❑ Depression with highs and lows ❑ Drug problem ❑ Mental illness

Does or did any other member of your family have any of the following conditions?

(Check all that apply.)

❑ Drugs ❑ Depression ❑ Mental illness ❑ Alcohol ❑ Diabetes ❑ Epilepsy

If so, state who:

_____

_____

_____

_____

How would you describe your spiritual or religious beliefs?

_____

_____

_____

_____

_____

_____

Regarding your education, what is the last grade completed (degree)?

_____

_____

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

- ❑ Happy childhood
- ❑ Eating disorder
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Unhappy childhood
- ❑ School problems
- ❑ Medical problems
- ❑ Emotional problems
- ❑ Family problems
- ❑ Alcohol abuse
- ❑ Legal trouble
- ❑ Drug abuse
- ❑ Behavior problems
- ❑ Other (describe below)

Other problems:

_____

_____

_____

_____

_____

_____

_____

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

Describe your father's (or father figure's) personality and his methods of discipline (past and present):

How did your father (or father figure) show affection, and how often did he share affection with you?

With others in the family, past and present?

Describe your mother's (or mother figure's) personality and methods of discipline (past and present):

How did your mother (or mother figure) show affection, and how often did she share affection with you?

With others in the family, past and present?

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

_____

_____

_____

_____

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

_____

_____

_____

_____

What did your father (or father figure) do to control the expression of affection in the family?

_____

_____

_____

_____

What did your mother (or mother figure) do to control the expression of affection in the family?

_____

_____

_____

_____

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

_____

_____

_____

_____

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: _____ What is your weight? _____

Do you now have, or have you ever had any of the following? *(Check all that apply.)*

- ❑ High blood pressure
- ❑ Unusual physical symptoms
- ❑ Epilepsy
- ❑ Alcohol problems
- ❑ Strange or unusual sensations
- ❑ Drug problems

Other illnesses: _____

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

If yes, when and where? _____

_____

_____

_____

Do you have a family physician? ❑ Yes ❑ No

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

_____

_____

Have you attempted suicide? ❑ Yes ❑ No

Have you ever seriously contemplated suicide? ❑ Yes ❑ No

What is your current health?

_____

_____

What kinds of jobs have you held in the past?

_____

_____

What sort of work are you doing now?

_____

_____

Does your present work satisfy you? ❑ Yes ❑ No

If not, please explain:

_____

_____

What is your annual family income? _____

How much does it cost you to live? _____

What were your dreams/goals when you were younger?

_____

_____

_____

_____

What are your current dreams/goals?

_____

_____

_____

_____

Check any of the following behaviors that apply to you:

- ❑ Overeating
- ❑ Odd behavior
- ❑ Crying
- ❑ Excessive fear
- ❑ Outbursts of temper
- ❑ Lazy
- ❑ Loss of control
- ❑ Drinking too much
- ❑ Suicidal attempts
- ❑ Difficulty concentrating
- ❑ Sleep disturbance
- ❑ Excessive risk-taking
- ❑ Impulsive reactions
- ❑ Taking drugs
- ❑ Smoking
- ❑ Vomiting
- ❑ Nervous tic
- ❑ Insomnia
- ❑ Aggressive behavior
- ❑ Procrastination
- ❑ Working too hard
- ❑ Compulsion
- ❑ Withdrawal
- ❑ Can’t keep a job
- ❑ Eating problems
- ❑ Excessive sexual behavior
- ❑ Other: _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

_____

Menstrual History (if applicable)

Age at first period: _____

Were you informed or did it come as a shock? _____

Are your periods regular? ❑ Yes ❑ No Do you have pain? ❑ Yes ❑ No

Does your period affect your mood? Explain: _____

Family Background

How long have you been in a relationship with your partner? _____

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

How long were you engaged? _____ How long have you been married? _____

Describe your parents' attitude toward sex:

_____

_____

Was sex discussed in your home? ❑ Yes ❑ No

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

_____

_____

Have you ever experienced feelings of anxiety or guilt from sex or masturbation? ❑ Yes ❑ No

If yes, please explain:

_____

_____

Any relevant details regarding your first or subsequent sexual experiences?

_____

_____

How satisfying is your present sex life? Please explain.

_____

_____

_____

Provide information about any significant homosexual reactions or relationships:

_____

_____

_____

Please note any sexual concerns not discussed above:

_____

_____

_____

Children and Family

Who parents your child(ren)? _____

Describe your methods of discipline (past and present):

_____

_____

_____

How do you show affection and how often do you share affection with our spouse/partner?

_____

_____

_____

With others in the family (past and present)?

_____

_____

Describe your spouse's/partner's methods of discipline (past and present):

_____

_____

_____

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

_____

_____

_____

With others in the family (past and present)?

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

What are the prevailing emotional overtones in your family?

_____

_____

_____

Do any of your children present special problems? If so, please explain.

_____

_____

_____

Stress

Check any of the following that apply, and indicate the family member(s) involved (i.e. spouse, child, father, mother, brother, sister, yourself, and so on.)

❑ Death in the family
❑ Divorce
❑ Trouble with the law; financial/job/school trouble
Family member(s) involved:

_____

_____

_____

_____

❑ Serious/chronic
❑ Illness
❑ Serious operation
❑ Mental illness

❑ Alcohol
❑ Drugs
❑ Interpersonal
❑ Other problems

Family member(s) involved:

_____

_____

_____

_____

❑ Sexual abuse (past or present)
❑ Depression/physical abuse/suicide
❑ Suicide attempt

❑ Other:
_____

Family member(s) involved:

_____

_____

_____

_____

Systems Outside of Your Family

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Has your minister/clergy made a special effort to talk to you about your behavior or the behavior of a member of your family?

_____

_____

_____

Have the police or other social agencies been involved with your family?

_____

_____

_____

Have there been any other outside disturbances to your family?

_____

_____

_____

Friendships

Rank your answers to the following questions using a scale of 1 to 5. *(1 = Not easily; 5 = Very easily)*

_____ Do you make friends easily?

_____ Do you have difficulty maintaining friendships?

_____ Do you keep them?

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

❑ Very relaxed ❑ Relatively comfortable ❑ Relatively uncomfortable ❑ Very anxious

Expectations Regarding Therapy:

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

_____

_____

_____

How long do you think therapy should last? _____

How do you think a therapist should interact with you?

_____

_____

_____

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

_____

_____

_____

CONSENT

By signing below, I hereby acknowledge that the information submitted on this form is accurate and correct to the best of my knowledge.

Signature: _____ Date: _____/_____/_____