



hypnodipity

## Life History Questionnaire

*The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions, as fully and as accurately as you can, you will provide your therapist with important information, without using your actual therapy time. Please share with me whatever information you feel might be helpful in our work together. Your answers will remain confidential.*

### General Health

How would you rate your current physical health?

Poor \_\_\_\_ Unsatisfactory \_\_\_\_ Satisfactory \_\_\_\_ Good \_\_\_\_ Excellent \_\_\_\_

How would you rate your current sleeping habits?

Poor \_\_\_\_ Unsatisfactory \_\_\_\_ Satisfactory \_\_\_\_ Good \_\_\_\_ Excellent \_\_\_\_

Describe your sleep schedule and any sleep issues. \_\_\_\_\_

\_\_\_\_\_

Have you been having any notable dreams? \_\_\_\_\_

\_\_\_\_\_

How many times a week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in? \_\_\_\_\_

Please describe any difficulties with your weight, appetite, or eating patterns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any current and chronic medical issues/challenges? \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for medical or mental illness? If so, list when, where & reason:

\_\_\_\_\_

\_\_\_\_\_



hypnodipity

## Life History Questionnaire

Please list any prescription or over-the-counter medications, including dosages and frequency.

---

---

Your medical care team: Doctors' name(s)/Phone numbers: \_\_\_\_\_

---

---

If you enter treatment with me, may I communicate with your medical doctor(s) to coordinate your treatment?

Yes  No  Maybe (Within Limits)

Do you drink alcohol or use recreational drugs? If so, what kind and how often? \_\_\_\_\_

---

Do you or anyone close to you consider your use to be a problem?  Yes  No  Debatable

### Present Relationships

Are you currently partnered or in a relationship?  Yes  No How long? \_\_\_\_\_

If yes, how do you get along with your partner or spouse? \_\_\_\_\_

---

Do you have children/grandchildren? If yes, what are their ages? \_\_\_\_\_

---

How do you get along with your children/grandchildren? \_\_\_\_\_

---



hypnodipity

## Life History Questionnaire

Briefly describe any other important relationships in your life and how satisfied you are with how they are going. \_\_\_\_\_

---

---

### Childhood & Family

Where were you born? Where did you grow up and live most of your childhood? \_\_\_\_\_

---

Briefly describe your family of origin (parents, siblings, etc.) and your childhood: \_\_\_\_\_

---

Parents? (Alive, divorced, how is your relationship with them?) \_\_\_\_\_

---

Siblings? (Close, distant, how is your relationship with them?) \_\_\_\_\_

---

Did you have serious illnesses/injuries OR physical/emotional trauma as a child? If so, and at what age?

---

### Education & Employment

What was the highest grade of education you completed? \_\_\_\_\_

Are you currently employed?  Yes  No

Are you currently a student?  Yes  No

Describe your current occupation/previous occupation(s). \_\_\_\_\_

---

Employer: \_\_\_\_\_ Length of time with this employer: \_\_\_\_\_



hypnodipity

## Life History Questionnaire

### Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

Please indicate which type of treatment:  Inpatient  Outpatient  Both  Other: \_\_\_\_\_

If yes, please indicate details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate type, duration, results: \_\_\_\_\_

\_\_\_\_\_

Do you have any family history of psychological/psychiatric disorders? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been suicidal in the past month?  Yes  No

Have you ever had thoughts of taking your life?  Yes  No

Have you ever acted on these thoughts?  Yes  No

If yes, please describe what happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has anyone in your family taken their own life or attempted suicide? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



hypnodipity

## Life History Questionnaire

Please check any of the following that have been bothering you lately:

<input type="checkbox"/>	Abused as Child	<input type="checkbox"/>	Agoraphobia	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	Ambition	<input type="checkbox"/>	Anger	<input type="checkbox"/>	Anger Management
<input type="checkbox"/>	Anxiety/Stress	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	Being a Parent
<input type="checkbox"/>	Bladder/Bowel Issues	<input type="checkbox"/>	Career Choices	<input type="checkbox"/>	Children
<input type="checkbox"/>	Compulsions	<input type="checkbox"/>	Compulsivity	<input type="checkbox"/>	Concentration
<input type="checkbox"/>	Confidence	<input type="checkbox"/>	COVID-19 Fears	<input type="checkbox"/>	COVID-19 Losses
<input type="checkbox"/>	COVID-19 Recovery	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Divorce
<input type="checkbox"/>	Drug Use/Abuse	<input type="checkbox"/>	Eating Problem(s)	<input type="checkbox"/>	Education
<input type="checkbox"/>	Energy (High/Low)	<input type="checkbox"/>	Extreme Fatigue	<input type="checkbox"/>	Family Member (Dementia)
<input type="checkbox"/>	Fears/Phobias	<input type="checkbox"/>	Feeling Suicidal	<input type="checkbox"/>	Finances
<input type="checkbox"/>	Friends	<input type="checkbox"/>	Grief	<input type="checkbox"/>	Guilt
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Health Problems	<input type="checkbox"/>	Inferiority Feelings
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	Making Decisions
<input type="checkbox"/>	Marriage	<input type="checkbox"/>	Memory	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Obsessive Thinking	<input type="checkbox"/>	Overweight
<input type="checkbox"/>	Painful Thoughts	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Physical Pain
<input type="checkbox"/>	Relationships	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	Self-Esteem
<input type="checkbox"/>	Self-Harm (Cutting, etc)	<input type="checkbox"/>	Separation	<input type="checkbox"/>	Sexual Problems
<input type="checkbox"/>	Short Temper	<input type="checkbox"/>	Shyness	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	Suicidal Thoughts	<input type="checkbox"/>	Weight Issues	<input type="checkbox"/>	Work



hypnodipity

## Life History Questionnaire

Please indicate (check) how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Use the following scale:

1. No Effect
2. Little Effect
3. Some Effect
4. Much Effect
5. Significant Effect
6. Doesn't Apply

Areas of Life Effected	1 No Effect	2 Little Effect	3 Some Effect	4 Much Effect	5 Significant Effect	6 Doesn't Apply
Marriage/Relationship						
Family						
Job/School Performance						
Friendships						
Financial Situation						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Sexual Functioning						
Alcohol/Drug Use						
Ability to Concentrate						
Ability to Control Anger						



# hypnodipity

## Life History Questionnaire

### More About You

How would you describe important aspects of your cultural/ethnic identity that would be important for me to consider as your hypnotherapist? \_\_\_\_\_

\_\_\_\_\_

Do you consider yourself spiritual or religious? If so, describe your spirituality/faith and your level of participation in a faith-based group. \_\_\_\_\_

\_\_\_\_\_

What do you consider your greatest strengths/ sources of resilience? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_