

# Life History Questionnaire (Confidential)



Date: \_\_\_\_\_ Therapist Name: \_\_\_\_\_

Office Location:   Downingtown    West Chester    Kennett Square    Audubon    Coatesville

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

If child provide Parent/Guardian Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male  Female

Home Phone #: \_\_\_\_\_ May we leave a message? No  Yes

Cell Phone #: \_\_\_\_\_ May we leave a message? No  Yes

Email Address: \_\_\_\_\_

## Emergency Contacts

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

We welcome people of all faiths, or no faith, without judgment or pressure. Would you like your faith included in your therapy? Yes  No  Unsure

Ethnicity: Asian/Pacific Islander  American Indian  Caucasian  Hispanic  African American  Other

Relationship Status: Single  Married  Year (s) \_\_\_\_\_ Divorced  Time(s) \_\_\_\_\_ Engaged

Wedding Date \_\_\_\_\_ Separated  Month(s) \_\_\_\_\_ Widowed

Education (last level completed): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Since: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Education (last level completed): \_\_\_\_\_ Employer: \_\_\_\_\_

Please list the names and ages of your children: \_\_\_\_\_

(Continued other side)

**Physical Health**

Very Good  Good  Poor

Recent Major Illnesses or Disabilities: \_\_\_\_\_

Are you currently taking any prescription medications? No  Yes  (If Yes, please list and specify dosage): \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Thyroid Level Checked No  Yes

**Mental Health**

Have you previously been involved in counseling? No  Yes

Do you currently use alcohol or other non-prescription drugs? No  Yes

Is there a history of alcohol or drug problems in your family? No  Yes

Is there any history of mental health problems in your family? No  Yes

Have you ever been physically abused? No  Yes

Have you ever been emotionally abused? No  Yes

Have you ever been sexually abused or assaulted? No  Yes

Are your concerns interfering with your work performance? No  Yes

Are your concerns interfering with your family life? No  Yes

Have you ever attempted suicide? No  Yes

Have you ever been hospitalized for mental health reasons? No  Yes

Have you ever been in legal trouble? No  Yes

How long has the problem that you are coming in for persisted? \_\_\_\_\_

Under what condition do your problems get worse? Better? \_\_\_\_\_

How serious do you consider your present concern(s)? Not at all  Mildly  Moderately  Highly

How motivated are you to resolve your concern(s)? Not at all  Mildly  Moderately  Highly

How optimistic are you that your concern(s) can be resolved? Not at all  Mildly  Moderately  Highly

**Family History**

Mother's age: \_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_

Father's age: \_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_

If your parents are separated, how old were you then? \_\_\_\_\_

Number of brother(s): \_\_\_\_\_ What are their ages? \_\_\_\_\_

Number of sister(s): \_\_\_\_\_ What are their ages? \_\_\_\_\_

If you were adopted or raised with parents other than your natural parents, please explain: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your mother's personality: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your father's personality: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your step-parent(s) personality: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your past and current relationships with your:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Stepmother: \_\_\_\_\_

Stepfather: \_\_\_\_\_



## Consent to Treatment / Confidentiality Policy

All therapists at The Peacemaker Center are experienced and professionally trained. I/We understand the relationship established with our therapists is voluntary and I/we have the right to end the relationship at any time. All client information and client records are strictly confidential. Information is shared only with authorized professional staff, including clinical supervisors, and the persons I/we have listed below. The only exceptions to this policy are as follows:

- If our staff has reason to believe that a child has been physically or sexually abused, we are required by law to report it to the state protection service. We are not making a determination that any behavior is unlawful or improper. That determination is made by the state.
- If our staff has reason to believe that a client may seriously harm him/herself or another person, we are required to release information to protect the person who may be harmed.
- Selected records may be made available to certifying or licensing organization for review of our record-keeping procedures.
- If information is shared during an individual counseling session that will impact the couples' therapy or relationship, the therapist may share that information with the spouse/partner. Either spouse/partner may choose to end couple's therapy and begin individual therapy, at which point, information shared would be confidential, even from the spouse/partner.
- If you choose to have electronic therapy, through the use of cell phones, email, video conferencing, etc. please understand the security risks that are included. The Peacemaker Center therapists will do their best to ensure confidentiality and security, but with technology, confidentiality and security cannot always be guaranteed.
- Children under the age of 14 need signed parental consent from both parents or all legal guardian(s) for treatment.

In the treatment of a couple or a family, The Peacemaker Center will seek the authorization of all member of the treatment unit before the release of confidential information to third parties. I/We understand in order to protect confidentiality, any inquiries other than the below-mentioned exception (written, telephone or personal) will not be answered until I/we sign a separate release of information.

I/We allow the following person to hear conveyed information from counseling sessions:

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**Litigation Limitation**

As a participant in therapy at The Peacemaker Center I/we understand and agree that no employee, agent, or principal of The Peacemaker Center shall be called as a witness to testify on our behalf, or on behalf of our children in any legal proceedings concerning my/our therapy. Further, I/we understand and agree for myself/ourselves, and for those who would represent us, that no documentation, other than recommendations, prepared in conjunction with The Peacemaker Center shall be subject to subpoena or records deposition for use in legal proceedings. I/we understand that this provision is necessary in order to foster frank, open, and meaningful exchanges between myself/ourselves and my/our therapist. I/We understand that I am/we are giving up our right to use testimony, records, or other information contained at The Peacemaker Center, but that I/we do so voluntarily, and without undue influence, for the purpose of establishing confidentiality and privilege for myself and The Peacemaker Center, which right and privilege shall not hereafter be revoked by me or my legal representative. I/We understand that the only communication between The Peacemaker Center and/or Court will be limited to a form letter stating when the services were begun and/or whether the client completed, did not complete, or are still undergoing therapy

**Payment Policies / Fee Scale**

Since the therapist’s time has been reserved, I/we agree to give at least 24-hour advance notice when unable to keep an appointment. If there is less than 24 hours, a fee may be charged. I/We accept financial responsibility for charges incurred during the course of having The Peacemaker Center provide services, including bank fees for returned checks. I/We understand the payment policies for private sessions and that full pay is \$125 per hourly session. I/We understand that for my sessions an hourly fee of \$\_\_\_\_\_ has been determined by my therapist.

I/We acknowledge by our individual signatures below, that each of us has read this policy, that I/we understand it and have had an opportunity to discuss its content and that I/we enter therapy in agreement with this policy.

Therapist Signature	Print Therapist Name	Date
Office Location:    Downingtown <input type="checkbox"/> West Chester <input type="checkbox"/> Kennett Square <input type="checkbox"/> Audubon <input type="checkbox"/> Coatesville <input type="checkbox"/>		
Signature (Client, Parent, or Guardian)	Print Client Name	Date
Signature	Print Name	Date
Signature	Print Name	Date