MULTIMODAL LIFE HISTORY INVENTORY

The purpose of this inventory is to obtain a comprehensive picture of your background. In psychotherapy records ass necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can. You will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time (please feel free to use extra sheets if you need additional answer space).

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal.

Case records are strictly confidential.

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GENERAL INFORMATION

Date: _____

Name: _____

Address: _____

Telephone numbers: Day_____ Evening_____

Age: _____ Occupation: _____ Sex: ____ M ____ F

Date of birth: _____ Weight: _____ Does your weight fluctuate? ____ Yes ____ No. If yes, by how much? _____

Do you have a family physician? ____ Yes ____ No

Name of family physician: _____ Telephone number: _____

By whom were you referred? _____

Marital status (check one): ____ Single ____ Engaged ____ Married ____ Separated ____ Divorced

____ Widowed ____ Living with someone ____ Remarried: How many times?
_____

Do you live in: ____ House ____ Room ____ Apartment ____ Other: _____

With whom do you live? (check all that apply): ____ Self ____ Parents ____Spouse ____ Roommate

____ Child(ren) ____ Friend(s) ____Others (specify): _____

What sort of work are you doing now? _____

Does your present work satisfy you? ____ Yes ____ No

If no, please explain: _____

_____

What kinds of jobs have you held in the past? _____

_____

Have you been in therapy before or received any professional assistance for your problems? ____ Yes ____ No

Have you ever been hospitalized for psychological/psychiatric problems? ____ Yes ____ No

If yes, when and where? _____

_____

Have you ever attempted suicide? ____ Yes ____ No

Does any member of your family suffer from an "emotional" or "mental disorder"? ____ Yes ____ No

Has any relative attempted or committed suicide? ____ Yes ____ No

PERSONAL AND SOCIAL HISTORY

Father: Name: _____ Age:_____

Occupation: _____ Health: _____

If deceased, give his age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Mother: Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, give her age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Siblings: Age(s) of brother(s): _____ Age(s) of sister(s): _____

Any significant details about siblings: _____

_____

_____

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

_____

_____

Give a description of your father's (or father substitute's) personality and his attitude toward you (past and present):

_____

_____

_____

_____

_____

Give a description of your mother's (or mother substitute's) personality and her attitude toward you (past and present):

_____

_____

_____

_____

_____

In what ways were you disciplined or punished by your parents?

_____

_____

_____

_____

Give an impression of your home atmosphere (i.e. the home in which you grew up). Mention state of compatibility between parents and between children.

_____

_____

_____

_____

_____

Were you able to confide in your parents? ____ Yes ____ No

Basically, did you feel loved and respected by your parents? ____ Yes ____ No

If you have a stepparent, give your age when your parent remarried: _____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.? ____ Yes ____ No

If yes, please describe briefly: _____

_____

_____

Scholastic strengths: _____

Scholastic weaknesses: _____

What was the last grade completed (or highest degree)? _____

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

____Happy childhood	____ Not enough friends	____ Sexually abused
____Unhappy childhood	____ School problems	____Severely bullied or teased
____Emotional/behavior problems	____Financial problems	____Eating disorder
____ Legal trouble	____ Strong religious convictions	____ Others: _____
____ Death in family	____ Drug use	_____
____ Medical problems	____ Used alcohol	_____
____ Ignored	____ Severely punished	_____

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problems: _____

_____

_____

_____

_____

_____

On the scale below, please estimate the severity of your problem(s):

____ Mildly upsetting ____Moderately upsetting ____ Very severe ____ Extremely severe ____ Totally incapacitating

When did your problems begin? _____

_____

What seems to worsen your problems? _____

_____

What have you tried that has been helpful? _____

_____

How satisfied are you with your life as a whole these days?

Not at all satisfied 1 2 3 4 5 6 7 Very satisfied

How would you rate your overall level of tension during the past month?

Relaxed 1 2 3 4 5 6 7 Tense

EXPECTATIONS REGARDING THERAPY

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

_____

_____

How long do you think your therapy should last? _____

_____

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

_____

_____

MODALITY ANALYSIS OF CURRENT PROBLEMS

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven modalities of Behaviors, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships, and Biological Factors.

BEHAVIORS

Check any of the following behaviors that often apply to you:

____ Overeat	____ Loss of control	____ Phobic avoidance	____ Crying
____ Take drugs	____ Suicidal attempts	____ Spend too much money	____ Outbursts of temper
____ Unassertive	____ Compulsions	____ Can't keep a job	____ Others: _____
____ Odd behavior	____ Smoke	____ Insomnia	_____
____ Drink too much	____ Withdrawal	____ Take too many risks	_____
____ Work too hard	____ Nervous tics	____ Lazy	
____ Procrastination	____ Concentrations difficulties	____ Eating Problems	
____ Impulsive reactions	____ Sleep disturbance	____ Aggressive behavior	

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

_____

What would you like to stop doing? _____

_____

How is your free time spent? _____

_____

What kind of hobbies or leisure activities do you enjoy or find relaxing? _____

_____

Do you have trouble relaxing or enjoying weekends and vacations? ____ Yes ____ No

If yes, please explain: _____

_____

_____

If you could have any two wishes, what would they be? _____

_____

_____

FEELINGS

Check any of the following feelings that often apply to you:

____ Angry ____ Fearful ____ Happy ____ Hopeful ____ Bored ____ Optimistic

____ Annoyed ____ Panicky ____ Conflicted ____ Helpless ____ Restless ____ Tense

____ Sad ____ Energetic ____ Shameful ____ Relaxed ____ Lonely ____ Others: _____

____ Depressed ____Envious ____ Regretful ____ Jealous ____ Contented _____

____ Anxious ____ Guilty ____ Hopeless ____ Unhappy ____ Excited _____

List your five main fears:

1. _____

2. _____

3. _____

4. _____

5. _____

What are some positive feelings you have experienced recently? _____

_____

When are you most likely to lose control of your feelings? _____

_____

Describe any situations that make you feel calm or relaxed: _____

_____

PHYSICAL SENSATIONS

Check any of the following physical sensations that often apply to you:

___ Abdominal pain ___ Bowel disturbances ___ Hear things ___ Blackouts

___ Pain or burning with urination ___ Tingling ___ Watery eyes ___ Excessive sweating

___ Menstrual difficulties ___ Numbness ___ Flushes ___ Visual disturbances

___ Headaches ___ Stomach trouble ___ Nausea ___ Hearing problems

___ Dizziness ___ Tics ___ Skin problems ___ Others: _____

___ Palpitations ___ Fatigue ___ Dry mouth _____

___ Muscle spasms ___ Twitches ___ Burning or itching skin _____

___ Tension ___ Back pain ___ Chest pains

___ Sexual disturbances ___ Tremors ___ Rapid heart beat

___ Unable to relax ___ Fainting spells ___ Don't like to be touched

What sensations are:

Pleasant to you? _____

Unpleasant to you? _____

IMAGES

Check any of the following that apply to you:

I picture myself:

___ Being happy
___ Being talked about
___ Being trapped
___ Being hurt
___ Being aggressive
___ Being laughed at
___ Not coping
___ Being helpless
___ Being promiscuous
___ Succeeding
___ Hurting others
___ Others: _____
___ Losing control
___ Being in charge
_____
___ Being followed
___ Failing
_____

I have:

___ Pleasant sexual images
___ Seduction images
___ Unpleasant childhood images
___ Images of being loved
___ Negative body images
___ Others: _____
___ Unpleasant sexual images
_____
___ Lonely images
_____

Describe a very pleasant image, mental picture, or fantasy: _____

_____

_____

Describe a very unpleasant image, mental picture, or fantasy: _____

_____

_____

Describe your image of a completely "safe place": _____

_____

Describe any persistent or disturbing images that interfere with your daily functioning: _____

_____

_____

How often do you have nightmares? _____

THOUGHTS

Check each of the following that you might use to describe yourself:

___ Intelligent	___ A nobody	___ Inadequate	___ Concentration difficulties	___ Lazy
___ Confident	___ Useless	___ Confused	___ Memory problems	___ Untrustworthy
___ Worthwhile	___ Evil	___ Ugly	___ Attractive	___ Dishonest
___ Ambitious	___ Crazy	___ Stupid	___ Can't make decisions	___Others: _____
___ Sensitive	___ Morally degenerate	___ Naïve	___ Suicidal ideas	_____
___ Loyal	___ Considerate	___ Honest	___ Persevering	_____
___ Trustworthy	___ Deviant	___ Incompetent	___ Good sense of humor	
___ Full of regrets	___ Unattractive	___ Horrible thoughts	___ Hard working	
___ Worthless	___ Unlovable	___ Conflicted	___ Undesirable	

What do you consider to be your craziest thought or idea? _____

_____

Are you bothered by thoughts that occur over and over again? ____ Yes ____ No

If yes, what are these thoughts? _____

_____

What worries do you have that may negatively affect your mood or behavior? _____

_____

On each of the following items, please circle the number that most accurately reflects your opinions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
I should not make mistakes.		1	2	3	4	5
I should be good at everything I do.		1	2	3	4	5
When I do not know something, I should pretend that I do.		1	2	3	4	5
I should not disclose personal information.		1	2	3	4	5
I am a victim of circumstances.		1	2	3	4	5
My life is controlled by outside forces.		1	2	3	4	5
Other people are happier than I am.		1	2	3	4	5
It is very important to please other people.		1	2	3	4	5
Play it safe: don't take any risks.		1	2	3	4	5
I don't deserve to be happy.		1	2	3	4	5
If I ignore my problems, they will disappear.		1	2	3	4	5
It is my responsibility to make other people happy.		1	2	3	4	5
I should strive for perfection.		1	2	3	4	5
Basically, there are two ways of doing things-the right way and the wrong way.		1	2	3	4	5
I should never be upset.		1	2	3	4	5

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? ____ Yes ____No Do you keep them? ____Yes ____No

Did you date much during high school? ____Yes ____No College? ____Yes ____No

Were you ever bullied or severely teased? ____ Yes ____ No

Describe any relationship that gives you:

Joy: _____

_____

Grief: _____

_____

Rate the degree to which you generally feel relaxed and comfortable in social situations:
Very relaxed 1 2 3 4 5 6 7 Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts? ____ Yes ____No

Marriage (or a committed relationship)

How long did you know your spouse before your engagement? _____

How long were you engaged before you got married? _____

How long have you been married? _____

What is your spouse's age? _____ His/her occupation? _____

Describe your spouse's personality: _____

_____

_____

What do you like most about your spouse? _____

_____

_____

What do you like least about your spouse? _____

_____

_____

What factors detract from your marital satisfaction? _____

_____

_____

On the scale below, please indicate how satisfied you are with your marriage:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your partner's friends and family?

Very poorly 1 2 3 4 5 6 7 Very well

How many children do you have? _____

Please give their names and ages: _____

_____

Do any of your children present special problems? ____Yes ____No

If yes, please describe: _____

_____

Any significant details about a previous marriage(s)? _____

_____

_____

Other Relationships

Are there any problems in your relationships with people at work? ____ Yes ____ No

If yes, please describe: _____

_____

Please complete the following:

One of the ways people hurt me is: _____

_____

I could shock you by: _____

_____

My spouse (or boyfriend/girlfriend) would describe me as: _____

_____

My best friend thinks I am: _____

_____

People who dislike me: _____

_____

Are you currently troubled by any past rejections or loss of a love relationship? ____ Yes ____ No

If yes, please explain: _____

Do you have any current concerns about your physical health? ____ Yes ____ No

If yes, please specify: _____

_____

_____

_____

Please list any medication you are currently taking: _____

_____

_____

Do you eat three well-balanced meals each day? ____ Yes ____ No

Do you get regular physical exercise? ____ Yes ____ No

If yes, what type and how often? _____

_____

_____

Please list any significant medical problems that apply to you or to members of your family: _____

_____

_____

_____

Please describe any surgery you have had (give dates): _____

_____

_____

_____

Please describe any physical handicap(s) you have: _____

_____

_____

Menstrual History (females)

Age at first period: _____ Were you informed? ___ Yes ___ No Did it come as a shock? ___ Yes ___ No

Are you regular? ___ Yes ___ No Duration: _____ Do you have pain? ___ Yes ___ No

Do you periods affect your moods? ___ Yes ___ No Date of last period: _____

Check any of the following that apply to you:

	Never	Rarely	Occasionally	Daily
Muscle weakness				
Tranquilizers				
Diuretics				
Diet pills				
Marijuana				
Hormones				
Sleeping pills				
Aspirin				
Cocaine				
Pain killers				
Narcotics				
Stimulants				
Hallucinogens(i.e.LSD)				
Laxatives				
Cigarettes				
Tobacco(specify)				
Coffee				
Alcohol				
Birth control pills				
Vitamins				
Under eat				
Overeat				
Eat junk foods				
Diarrhea				
Constipation				
Gas				
Indigestion				
Nausea				
Vomiting				
Heartburn				
Dizziness				
Palpitations				
Fatigue				
Allergies				
High blood pressure				
Chest Pain				
Shortness of breath				
Insomnia				
Sleep too much				
Fitful sleep				
Early morning awakening				
Earaches				
Headaches				
Backaches				
Bruise or bleed easily				
Weight problems				
Others:				

STRUCTURAL PROFILE

Directions: Rate yourself on the following dimensions on a seven-point scale with "1" being the lowest and "7" being the highest.

BEHAVIORS:	Some people may be described as "doers" – they are action oriented, they like to busy themselves, get things done, take on various projects. How much of a doer are you?	1	2	3	4	5	6	7
FEELINGS:	Some people are very emotional and may or may not express How passionate are you?	1	2	3	4	5	6	7
PHYSICAL SENSATIONS:	Some people attach a lot of value to sensory experiences, such as sex, food, music, art, and other "sensory delights." Others are very much aware of minor aches, pains and discomforts How "tuned into" your sensations are you?	1	2	3	4	5	6	7
MENTAL IMAGES:	How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is "thinking in pictures," visualizing real or imagined experiences, letting your mind roam. How much are you into imagery?	1	2	3	4	5	6	7
THOUGHTS:	Some people are very analytical and like to plan things. They like to reason things through. How much of a 'thinker" and "planner" are you?	1	2	3	4	5	6	7
INTERPERSONAL RELATIONSHIPS:	How important are other people to you? This is you self-rating as a social being. How important are close friendships' To you, the tendency to gravitate toward people, the desire for intimacy? The opposite of this is being a "loner."	1	2	3	4	5	6	7
BIOLOGICAL FACTORS:	Are you healthy and health conscious? Do you avoid bad habits like smoking, too much alcohol, drinking a lot of coffee, overeating, etc.? Do you exercise regularly, get enough sleep, avoid junk foods, and generally take care of your body?	1	2	3	4	5	6	7

Please describe any significant childhood (or other) memories and experiences you think your therapist should be aware of: