MARRIAGE & FAMILY THERAPY
of WESTERN NEW YORK

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Marital and Family Life History Questionnaire

The purpose of this questionnaire is to get a complete picture of your marital and family background. In marriage and family therapy, we are concerned with issues that affect you, your marriage, and your family from many sources. Among those sources are (a) your family of origin, that is your parents and grandparents (b) your physical health (c) your life history and (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 as 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 strictly confidential. NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR PERMISSION IN WRITING.

If you have any questions about this questionnaire, please feel free to ask at any time. Many of the questions are personal and may not be or seem relevant to your situation. If you do not wish to answer a question, you may indicate that in the blank. Please use the back of the page if you want to write more than space allows. As indicated in my No Secrets Policy, if you are seeking couples therapy, any information provided here may be shared with the other member of the couple, at the therapist's discretion.

DATE______________________________

General Information:

Name: ____ Birthdate: _______________ Age: ______

Partner's Name: ____ Age: _______________

Children's Names: _______________________________________ Sex ______ Age: _______________

____ Sex _______ Age: ________________

____ Sex _______ Age: ________________

Who else lives in your house (relationship to you and ages)? ____

____

Address: ____

____

Telephone Numbers: (days) ___________________________ (Evenings) _____________________________

Email address: ____

Would you like to be placed on our email mailing list? Yes No

Your occupation: ____

Does your present work satisfy you? Yes No

If no, please explain: ____

Your partner's occupation: __________________________________

Does his/her present work satisfy him/her? Yes No

If no, please explain: ____

Have you or your immediate family served in the military? Yes No

How did you find out about this practice (please check all that apply):

From a friend (name) _________________________ Google Psychology Today.com
My doctor (name) ____ AAMFT/Therapist Locator.net
My attorney (name) __________________________________ On the radio
Another therapist (name) _________________________________
Other ____

Please state in your own words the nature of your main problem(s):

____

____

____

When did your problem(s) begin (give date if possible): ______________________________________

Please describe any important events occurring at that time or since then which may have started the problem(s) or which keep them going:

____

____

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

____

____

____

Current Relationship Status: Single Engaged Married Committed monogamous
Committed polyamorous Separated Divorced Widowed Remarried

Past significant relationships/marriages for you or your partner (please list how long the relationship lasted and when it ended)

____

____

____

Have you been in therapy before or received any prior professional assistance for your problem(s)? If so, please give names, professional titles, and approximate dates of treatment:

Name of provider	**Who attended?**	**Dates of treatment**	**Was it helpful?**
			Yes

			No
			Yes No
			Yes No

Please list any medication that you, your partner, or your children are taking for moods or behavior, and who is taking it.

____

____

____

Please check if any of the following have been issues (or are currently issues) in your family or in your partner's family? Please consider you, your partner, your parents, brothers and sisters, those of your partner, and also your children.

Behavior	Who experienced it?
Aggression	
Attention/impulse control	
Learning disabilities	
School problems	
Developmental disability/MR	
Psychosis or schizophrenia	
Depression	
Depression with highs and lows	
Anxiety	
Tics or Tourette's	
Alcohol/substance abuse	
Arrests/legal trouble	
Verbal/emotional abuse	
Physical abuse	
Sexual abuse	
Self-harm (cutting, burning, etc.)	
Suicide (including attempts)	
Eating disorder (overeating, restricting, bingeing, purging)	
Psychiatric hospitalization	
Phobic avoidance	
Withdrawal	
Sleep disturbance	
Can't keep a job	
Procrastination	
Work too hard	
Compulsions	
Difficulty concentrating	
Outbursts of temper	
Impulsive reactions	
Takes too many risks	

Mother: Living? _____ If alive, give mothers age: ___
Deceased? ______ If deceased, age at time of death: ___
How old were you at the time? ______________________
Cause of Death: __________________________________
Occupation: _____________________________________
Health: ____
Married to your father? Yes No
Married to someone else? Yes No

Father: Living? ____ If alive, give father's age ____
Deceased? ______ If deceased, age at time of death: ___
How old were you at the time? ______________________
Cause of Death: __________________________________
Occupation: _____________________________________
Health: ____
Married to someone other than your mother? Yes No

Your religion/spirituality: As a child:
____
As an adult:
____

Your education: What is the last grade completed: ______________________________

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

How are you, your partner, and your respective parents when it comes to parenting?

	Personality	Warmth/Affection (High/Medium/Low)	Control/Strictness (High/Medium/Low)	Other descriptors
You				
Your partner				
Your mother				
Your father				
Partner's mother				
Partner's father				

Do you have a family physician? Yes No

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

____

Please list major medical problems, surgeries, accidents, illnesses in your family:

____
____

____
____

What kinds of hobbies or leisure activities do you and your partner enjoy or find relaxing, either alone or together?

____
____

____
____

5. Your Current Family

Marriage:

How long did you know your partner before your engagement?
____

How long were you engaged? ______________________

How long have you been married? __________________

Sexual Relationships:

Describe your parents' attitude toward sex:
____

____
____

____
____

Was sex discussed in your home? Yes No

Have you ever experienced any anxiety or guilty feelings arising out of sex or masturbation?
Yes No

If yes, please explain:
____

____
____

Are there any relevant details regarding your first or subsequent sexual experiences?
_____________________-
____

____
____

Is your present sex life satisfactory? Yes No

If not, please explain:

Please note any sexual concerns not discussed above:

Children and Family:

Give a description of your methods of discipline (Past and Present):

How do you show affection and how often do you share affection with your partner?

With others in the family? (Past and Present):

Give a description of your partner's methods of discipline (Past and Present):

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

With others in the family? (Past and Present)

What are the prevailing emotional overtones in your family?

Do any of your children present special problems?

____

____

Stress:

Check any of the following which apply and indicate the family member involved such as partner, child, father, mother, brother, sister, yourself and so on:

EVENT	Family Member(s) Involved
Death in the Family	
Divorce	
Trouble with the law	
Financial Trouble	
Job/School	
Serious Illness	
Serious Operation	
Mental Illness	
Alcohol	
Drugs	
Interpersonal Problems	
Sexual Abuse	
Depression	
Physical Abuse	
Suicide	
Other:	

What gives you the most joy or pleasure in your life?

____

____

What are your main worries or fears?

____

____

What are your most important hopes or dreams?

____

____

6. 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? If so, how? ____

____

Are you having any trouble on the job or in school? If so, what?

____

____

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

____

____

Have the police or other social agencies interfered in your family? Yes No

Do you have any open cases with Child Protective Services? Yes No

If yes, please provide the name and phone number of your CPS worker ____________________________

____

Have there been any other outside disturbances to your family? Yes No

Friendships:

Do you make friends easily? Yes No

Do you keep them? Yes No

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?

____

What are your goals for therapy?

____

____