visionary vanguard GROUP, INC.

Vanguard Wellness
CENTER

___1200 Oakley Sever Dr. Ste. 203, Clermont, FL 34711

___1221 W. Colonial Dr. Ste. 202 Orlando, FL 32804

Life History Questionnaire
(All files are held in strict confidence)

Date _____ Therapist's Name:_____

First Name _____ MI _____ Last Name _____ Maiden _____

Age _____ Date Of Birth : _____ What is your Gender? _____

☐ Asian/Pacific Islander ☐ White

☐ American Indian ☐ Black

Are you Hispanic? YES / NO

Relationship Status

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address	City	State	Zip

Phone

Insurance Company_____ Member Number:_____

Name of Insured_____ Address for Claims:_____

Please indicate your language of preference below

☐ English ☐ Spanish ☐ Haitian Creole ☐ Other (Please specify below)

Who referred you to us?

Please read the following questions and mark those to which you would respond "yes."

☐ Have you previously been involved in counseling?
☐ Do you currently use alcohol or other non-prescription drugs?
☐ Is there a history of mental health problems in your family?
☐ Have you ever been physically abused?
☐ Have you ever been emotionally abused?
☐ Are your concerns interfering with your academic performance?
☐ Have you ever attempted suicide?
☐ Have you ever been hospitalized for mental health reasons?
☐ Is there a history of alcohol or drug problems in your family?
☐ Have you ever been in legal trouble?
☐ Have you ever been sexually abused or assaulted?
☐ Are you currently taking any prescription medications?
☐ Are your concerns interfering with your ability to work or stay in school?

Please describe the concerns that you would like to discuss with a counselor:

How long has this problem persisted?

Under what condition do your problems get worse? better?

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. How many times per week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?

□ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. What do you consider to be some of your strengths?

_____

_____

_____

3. What do you consider to be some of your weakness?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____

_____

_____

_____