

LIFE FUNCTIONING INVENTORY

This form is intended to help your counselor become better acquainted with you and in turn, serve you better. Please print the information requested or checkmark the appropriate responses. You may omit any item, but try to be as thorough as possible. Thank you.

SECTION A: Basic Client Information

Full Name: _____ **Address:** _____

City/State/Zip: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Fax: _____ **E-mail:** _____

Do you have any objections to being contacted by telephone, mail, e-mail, etc... yes no

How would you like to be contacted? _____

Date of Birth: _____ **Age:** _____ **Gender:** male female

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **E-mail:** _____

Referred by: _____

SECTION B: Presenting Problem Analysis

1. **Briefly describe the problem or concern you most wish help with currently:**

2. **How would you rate the intensity of the problem or concern that led you to seek professional services?**
(please circle)

Extremely Intense Moderately Intense Not Intense
5 4 3 2 1

3. **Approximately how long have you had the current problem or concern?** _____

4. **In what ways have you attempted to cope with this problem or concern?** _____

SECTION C: Cultural Background

1. What is your race/ethnicity?

- White (non-Hispanic/Latino) Hispanic/Latino Black/African American
 Asian American American Indian/Alaska Native Native Hawaiian/Pacific Islander
 Multiracial (please specify): _____
 International (please specify): _____

2. How much do you identify with your ethnic heritage? not at all a little somewhat moderately strongly

3. Religious or spiritual preference: _____

4. Are you currently active in your religion? yes somewhat no

5. Does your family speak a language other than English at home?

- not at all very little sometimes frequently always

If “sometimes” to “always,” what language is spoken? _____

6. Were you and both your biological parents born in the U.S.? yes no unsure

If no, who was foreign-born, from what country, and what was the approximate age of immigration to the U.S.?

SECTION D: Family Background

1. Please list the members of your current family.

<i>a. Father</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Education:</i>
<i>b. Mother</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Education:</i>
<i>c. Sibling one</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>d. Sibling two</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>e. Sibling three</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>f. Sibling four</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female

2. Is your father deceased? yes no Year? _____ **Is your mother deceased?** yes no Year? _____

3. What is/was your parents’ marital status? married divorced separated father remarried mother remarried

4. Please list your step-family members. (please circle “step” or “half”)

<i>a. Step-father</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Education:</i>
<i>b. Step-mother</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Education:</i>
<i>c. Step/half sibling one</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>d. Step/half sibling two</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>e. Step/half sibling three</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female
<i>f. Step/half sibling four</i>	<i>Age:</i>	<i>Occupation:</i>	<i>Gender:</i> <input type="checkbox"/> male <input type="checkbox"/> female

SECTION E: Education Information and Work History

1. Please indicate your educational level.

- less than high school H.S. equivalent/GED high school diploma
 vocational some college (no degree completed) bachelor's degree
 master's degree doctoral degree other _____

2. What was your major/minor/area of concentration? _____

3. Did you experience any learning problems in school?

- none little some substantial always/constant struggle

4. How satisfied are you with your academic progress so far? (please circle)

- very satisfied satisfied very dissatisfied
 5 4 3 2 1

5. What barriers, if any, are impeding your academic progress? _____

6. What is your current job and/or occupation? _____

7. Where are you employed? _____

8. How satisfied are you with your current job and or occupation? (please circle)

- very satisfied satisfied very dissatisfied
 5 4 3 2 1

9. Please list four most recent employers and dates of employment?

a. Employer one:	Dates of employment:
b. Employer two:	Dates of employment:
c. Employer three:	Dates of employment:
d. Employer four:	Dates of employment:

10. Have you ever been fired from a job? yes no

If yes, for what reason? _____

11. Have you ever walked off of a job? yes no

If yes, for what reason? _____

SECTION F: Health and Social Issues

1. How is your physical health at present? poor fair satisfactory good excellent

2. Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, diabetes, etc.)

3. Please list any prescribed medications you are presently taking.

4. **Are you having any problems with your sleep habits?** yes no
- If yes, check were applicable:** sleeping too little sleeping too much poor quality sleep
 disturbing dreams other _____
5. **How many times per week do you exercise?** _____ **For how long?** _____
6. **Are you having any difficulty with appetite or eating habits?** yes no
- If yes, check were applicable:** eating less eating more binge eating
 restricting calories significant weight change (in past two months)
7. **Do you regularly use alcohol?** yes no
- In a typical month, how often do you have 4 or more drinks in a 24 hr. period?** _____
8. **Have you ever tried to cut down on the amount of alcohol you consume?** yes no
9. **Has anyone close to you ever been annoyed by your drinking?** yes no
10. **Do you consider your alcohol consumption to be a problem?** yes no unsure
11. **How often do you engage in recreational drug use?** daily weekly monthly rarely never
12. **Do you consider this drug use to be a problem?** yes no unsure
13. **Have you ever experienced legal problems?** yes no **Nature of problem:** _____

14. **In the past, how would you rate the quality of your peer relationships?**
- very poor unsatisfactory average good excellent
15. **Approximately how many significant intimate relationships, lasting six months or more, have you had?** _____
- Are you currently in one?** yes no unsure
16. **Do you have any problems or worries about sexual functioning?** yes no
- If yes, check were applicable:** performance problem sexual impulsiveness lack of desire
 difficulty maintaining arousal worry about STD(s) other _____
17. **What is your sexual orientation?** heterosexual gay/lesbian bisexual unsure
18. **Besides family members, approximately how many people can you really count on currently for friendship or emotional support?** _____
19. **How do you spend your leisure time?** _____

SECTION G: Mental Health History

1. **Are you currently receiving psychiatric services, professional counseling or therapy elsewhere?** yes no

2. **Have you ever had previous counseling or psychotherapy?** yes no

If yes, please specify the following: Reason for counseling: _____
Counseling location: _____
Counseling date: _____
Counseling duration: _____

3. **Have you ever been hospitalized for psychiatric reasons?** yes no

If yes, please specify the following: Reason for hospitalization: _____
Hospital location: _____
Dates of hospitalization: _____
Duration of hospitalization: _____

4. **Have you ever been prescribed medication for psychiatric reasons?** yes no

If yes, please specify the following: Name/dose of medication: _____
Date of prescription: _____
Duration of medication: _____
Physician who prescribed medication: _____

5. **Have you had suicidal thoughts recently?** yes no **How often?** daily weekly monthly rarely

Have you had them in the past? yes no **How often?** daily weekly monthly rarely

6. **Have you ever intentionally inflicted harm upon yourself?** yes no

How often? daily weekly monthly rarely **Nature of harm:** _____

7. **Have you ever intentionally hurt someone else?** yes no **Nature of harm:** _____

8. **Have you ever experienced any form of traumatic experience?** yes no **When?** _____

Nature of experience: _____

9. **Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?**

frequently a few times once never unsure

10. **How does the future look to you?** poor fair neutral good excellent

11. **Please describe your future plans.** _____

12. **What do you hope to accomplish through counseling?** _____

13. **Is there anything else you would like your counselor to know about you?** _____

Thank you for your time and effort!