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:________________________________

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?

	Extremely Intense		Moderately Intense		Not Intense
(please circle)	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.

a. Father	*Age:*	*Occupation:*	*Education:*
b. Mother	*Age:*	*Occupation:*	*Education:*
c. Sibling one	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
d. Sibling two	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
e. Sibling three	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
f. Sibling four:	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*

2. Is your father deceased? ☐ yes ☐ no Year?_______ Is your mother deceased? ☐ yes ☐ no Year?_______

3. What is/was your parents' marital state?☐ married ☐ divorced ☐ separated ☐ father remarried ☐ mother remarried

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

a. Step-father	*Age:*	*Occupation:*	*Education:*
b. Step-mother	*Age:*	*Occupation:*	*Education:*
c. Step/hale Sibling one	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
d. Step/half Sibling two	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
e. Step/halfSibling three	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*
f. Step/half Sibling four:	*Age:*	*Occupation:*	*Gender:* ☐ *male* ☐ *female*

5. What is your relationship status?

☐ single ☐ divorced ☐ separated ☐ widowed ☐ married/committed relationship ☐ remarried

6. What is your spouse's/partner's: Age? ____________________ Occupation? ______________________________

Education? _______________ Deceased? ☐ yes ☐ no Year? ____________

7. Please list any children of yours.

a. Child one Age:	*Adopted?* ☐ *yes* ☐ *no*	*Gender:* ☐ *male* ☐ *female*
b. Child two Age:	*Adopted?* ☐ *yes* ☐ *no*	*Gender:* ☐ *male* ☐ *female*
c. Child three Age:	*Adopted?* ☐ *yes* ☐ *no*	*Gender:* ☐ *male* ☐ *female*
d. Child four Age:	*Adopted?* ☐ *yes* ☐ *no*	*Gender:* ☐ *male* ☐ *female*
e. Child five Age:	*Adopted?* ☐ *yes* ☐ *no*	*Gender:* ☐ *male* ☐ *female*

8. Please list any step-children of yours.

a. Step-child one Age:	*Gender:* ☐ *male* ☐ *female*
b. Step-child two Age:	*Gender:* ☐ *male* ☐ *female*
c. Step-child three Age:	*Gender:* ☐ *male* ☐ *female*
d. Step-child four Age:	*Gender:* ☐ *male* ☐ *female*
e. Step-child five Age:	*Gender:* ☐ *male* ☐ *female*

9. Please check any past, present, or impending problems/issues in your family:

☐ deaths
☐ financial crisis/unemployment
☐ debilitating injuries/disabilities
☐ easting disorders
☐ marital affairs/infidelity
☐ physical/sexual abuse
☐ frequent relocations
☐ attempted/completed suicide
☐ serious/chronic illness
☐ other __________________________
☐ divorce
☐ legal problems
☐ alcohol/drug abuse
☐ psychiatric disorder

Please specify family member(s), which problem/issue, and approximate year of occurrence:

____

____

10. Have you personally experienced significant abuse?

☐ none ☐ unsure ☐ emotional ☐ physical ☐ sexual

11. In general, how happy or adjusted were you growing up?

☐ poor ☐ unsatisfactory ☐ average ☐ substantial ☐ completely

12. How much is your immediate family a source of emotional support for you?

☐ none ☐ little ☐ somewhat ☐ substantial ☐ always

13. How much conflict in values do you currently experience with your parents?

☐ none ☐ little ☐ somewhat ☐ substantial ☐ always

14. Who in your family do you currently feel closest to? ____

Most distant from? __________________________ In most conflict with? _________________________________

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 competed) ☐ 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 where applicable: ☐ sleeping pills ☐ 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 loss ☐ 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 24hr 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 where 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 ever 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!