MUTIMODAL LIFE HISTORY INVENTORY

The purpose of this inventory is to obtain a comprehensive picture of your background. In psychotherapy records are 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.

Second edition. 1991

First edition. 1980. Published as the Multimodal Life History Questionnaire

Research Press

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Champaign, Illinois 61821

GENERAL INFORMATION **Date:** _____

Name: _____

Address: _____

Telephone numbers: Day: _____ **Evening:** _____

Age: _____ **Occupation:** _____ **Sex: Male** ☐ **Female** ☐

Date of Birth: _____ **Place of birth:** _____ **Religion:** _____

Height: _____ **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 kind of jobs have you held in the past?

Have you been in therapy before or received 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 the time of death: _____

How old were you at the time? _____ Cause of death: _____

Mother: **Name: _____ Age: _____**

Occupation: _____ Health: _____

If deceased, give her age at the 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
- ☐ Unhappy Childhood
- ☐ Emotional/Behavior Problems
- ☐ Legal Trouble
- ☐ Death in Family
- ☐ Medical Problems
- ☐ Ignored
- ☐ Not Enough Friends
- ☐ School Problems
- ☐ Financial Problems
- ☐ Strong Religious Convictions
- ☐ Drug Use
- ☐ Used Alcohol
- ☐ Severely Punished
- ☐ Sexually Abused
- ☐ Severely Bullied or Teased
- ☐ Eating Disorder
- ☐ Others:
- ☐ Others:
- ☐ Others:
- ☐ Others:

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:

☐ Over Eat	☐ 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	☐ Others:
☐ Drink too Much	☐ Withdrawal	☐ Take too Many Risks	☐ Others:
☐ Work too Hard	☐ Nervous Tics	☐ Lazy	
☐ Procrastination	☐ Concentration 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 start doing?

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	☐ Others:
☐ Anxious	☐ Guilty	☐ Hopeless	☐ Unhappy	☐ Excited	☐ Others:

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	☐ Others:
☐ Muscle Spasms	☐ Twitches	☐ Burning or Itching Skin	☐ Others:
☐ Tension	☐ Back Pain	☐ Chest Pain	
☐ Sexual Disturbances	☐ Tremors	☐ Rapid Heart Beat	
☐ Unable to Relax	☐ Fainting Spells	☐ Don't Like to Be Touched	

What sensations are:

Pleasant for you?

Unpleasant for you?

IMAGES

Check any of the following that apply to you:

I picture myself:

- ☐ Being Happy
- ☐ Being Hurt
- ☐ Not Coping
- ☐ Succeeding
- ☐ Losing Control
- ☐ Being Followed
- ☐ Being Talked About
- ☐ Being Aggressive
- ☐ Being Helpless
- ☐ Hurting Others
- ☐ Being in Charge
- ☐ Failing
- ☐ Being Trapped
- ☐ Being Laughed At
- ☐ Being Promiscuous
- ☐ Others:
- ☐ Others:
- ☐ Others:

I have:

- ☐ Pleasant Sexual Images
- ☐ Unpleasant Childhood Images
- ☐ Negative Body Images
- ☐ Unpleasant Sexual Images
- ☐ Lonely Images
- ☐ Seductive Images
- ☐ Images of Being Loved
- ☐ Others:
- ☐ Others:
- ☐ Others:

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	☐ Others:
☐ Loyal	☐ Considerate	☐ Honest	☐ Persevering	☐ Others:
☐ Trustworthy	☐ Deviant	☐ Incompetent	☐ Good Sense of Humor	☐ Others:
☐ 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 mark 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 –	**1**☐	**2**☐	**3**☐	**4**☐	**5**☐
the right way and the wrong way.					
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 the 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)?

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home?

When and how did you derive your first knowledge of sex?

When did you first become aware of your own sexual impulses?

Have you ever experienced any anxiety or guilt arising out of sex or masturbation? **Yes** ☐ **No** ☐

If yes, please explain:

Any relevant details regarding your first or subsequent sexual experiences?

Is your present sex life satisfactory? Yes ☐ No ☐ If No, please explain:

Provide information about any significant homosexual reactions or relationships:

Please note any sexual concerns not discussed above:

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:

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 it. How emotional are you? How deeply do you feel things? 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 "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 your 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 ☐

BIOLOGICAL FACTORS

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

If yes, please specify:

Please list any medications 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

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 your periods affect your moods? Yes ☐ No ☐ Date of last period:_____

Check any of the following that apply to you:

	Never	Rarely	Occasionally	Frequently	Daily
Muscle weakness	○	○	○	○	○
Tranquilizers	○	○	○	○	○
Diuretics	○	○	○	○	○
Diet pills	○	○	○	○	○
Marijuana	○	○	○	○	○
Hormones	○	○	○	○	○
Sleeping pills	○	○	○	○	○
Aspirin	○	○	○	○	○
Cocaine	○	○	○	○	○
Pain Killers	○	○	○	○	○
Narcotics	○	○	○	○	○
Stimulants	○	○	○	○	○
Hallucinogens (e.g. LSD)	○	○	○	○	○
Laxatives	○	○	○	○	○
Cigarettes	○	○	○	○	○
Tobacco (specify)	○	○	○	○	○
Coffee	○	○	○	○	○
Alcohol	○	○	○	○	○
Birth control pills	○	○	○	○	○
Vitamins	○	○	○	○	○
Undereat	○	○	○	○	○
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 to much	○	○	○	○	○
Fitful sleep	○	○	○	○	○
Early morning awakening	○	○	○	○	○
Earaches	○	○	○	○	○
Headaches	○	○	○	○	○
Backaches	○	○	○	○	○
Bruise or bleed easily	○	○	○	○	○
Weight problems	○	○	○	○	○
Others:	○	○	○	○	○
Others:	○	○	○	○	○
Others:	○	○	○	○	○

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