

## **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

## 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?	<input type="checkbox"/> yes <input type="checkbox"/> no	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
b. Child two	Age:	Adopted?	<input type="checkbox"/> yes <input type="checkbox"/> no	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
c. Child three	Age:	Adopted?	<input type="checkbox"/> yes <input type="checkbox"/> no	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
d. Child four	Age:	Adopted?	<input type="checkbox"/> yes <input type="checkbox"/> no	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
e. Child five	Age:	Adopted?	<input type="checkbox"/> yes <input type="checkbox"/> no	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female

## 8. Please list any step-children of yours.

a. Step-child one	Age:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
b. Step-child two	Age:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
c. Step-child three	Age:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
d. Step-child four	Age:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female
e. Step-child five	Age:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> deaths                             | <input type="checkbox"/> physical/sexual abuse       | <input type="checkbox"/> divorce              |
| <input type="checkbox"/> financial crisis/unemployment      | <input type="checkbox"/> frequent relocations        | <input type="checkbox"/> legal problems       |
| <input type="checkbox"/> debilitating injuries/disabilities | <input type="checkbox"/> attempted/completed suicide | <input type="checkbox"/> alcohol/drug abuse   |
| <input type="checkbox"/> eating disorders                   | <input type="checkbox"/> serious/chronic illness     | <input type="checkbox"/> psychiatric disorder |
| <input type="checkbox"/> marital affairs/infidelity         | <input type="checkbox"/> other _____                 |   |

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

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## 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    sometimes    substantial    always

## 14. Who in your family do you currently feel closest to? \_\_\_\_\_

Most distant from? \_\_\_\_\_ In most conflict with? \_\_\_\_\_

