

## MULTIMODAL 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.

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Research Press  
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**GENERAL INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone numbers: Day \_\_\_\_\_ Evening \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Sex:  M  F

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 any 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 time of death: \_\_\_\_\_ How old were you at the time? \_\_\_\_\_

Cause of death: \_\_\_\_\_

**Mother:** Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health: \_\_\_\_\_

If deceased, give her age at 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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Happy childhood             | <input type="checkbox"/> Not enough friends           | <input type="checkbox"/> Sexually abused            |
| <input type="checkbox"/> Unhappy childhood           | <input type="checkbox"/> School problems              | <input type="checkbox"/> Severely bullied or teased |
| <input type="checkbox"/> Emotional/behavior problems | <input type="checkbox"/> Financial problems           | <input type="checkbox"/> Eating disorder            |
| <input type="checkbox"/> Legal trouble               | <input type="checkbox"/> Strong religious convictions | <input type="checkbox"/> Others: _____              |
| <input type="checkbox"/> Death in family             | <input type="checkbox"/> Drug use                     | _____   |
| <input type="checkbox"/> Medical problems            | <input type="checkbox"/> Used alcohol                 | _____   |
| <input type="checkbox"/> Ignored                     | <input type="checkbox"/> Severely punished            | _____   |

**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:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Overeat             | <input type="checkbox"/> Loss of control            | <input type="checkbox"/> Phobic avoidance     | <input type="checkbox"/> Crying              |
| <input type="checkbox"/> Take drugs          | <input type="checkbox"/> Suicidal attempts          | <input type="checkbox"/> Spend too much money | <input type="checkbox"/> Outbursts of temper |
| <input type="checkbox"/> Unassertive         | <input type="checkbox"/> Compulsions                | <input type="checkbox"/> Can't keep a job     | <input type="checkbox"/> Others: _____       |
| <input type="checkbox"/> Odd behavior        | <input type="checkbox"/> Smoke                      | <input type="checkbox"/> Insomnia             | _____  |
| <input type="checkbox"/> Drink too much      | <input type="checkbox"/> Withdrawal                 | <input type="checkbox"/> Take too many risks  | _____  |
| <input type="checkbox"/> Work too hard       | <input type="checkbox"/> Nervous tics               | <input type="checkbox"/> Lazy                 |  |
| <input type="checkbox"/> Procrastination     | <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Eating problems      |  |
| <input type="checkbox"/> Impulsive reactions | <input type="checkbox"/> Sleep disturbance          | <input type="checkbox"/> 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    \_\_\_\_\_
- Anxious     Guilty     Hopeless     Unhappy     Excited    \_\_\_\_\_

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    \_\_\_\_\_
- Muscle spasms     Twitches     Burning or itching skin    \_\_\_\_\_
- Tension     Back pain     Chest pains
- 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 talked about

\_\_\_ Being trapped

\_\_\_ Being hurt

\_\_\_ Being aggressive

\_\_\_ Being laughed at

\_\_\_ Not coping

\_\_\_ Being helpless

\_\_\_ Being promiscuous

\_\_\_ Succeeding

\_\_\_ Hurting others

\_\_\_ Others: \_\_\_\_\_

\_\_\_ Losing control

\_\_\_ Being in charge

\_\_\_\_\_

\_\_\_ Being followed

\_\_\_ Failing

\_\_\_\_\_

I have:

\_\_\_ Pleasant sexual images

\_\_\_ Seduction images

\_\_\_ Unpleasant childhood images

\_\_\_ Images of being loved

\_\_\_ Negative body image

\_\_\_ Others: \_\_\_\_\_

\_\_\_ Unpleasant sexual images

\_\_\_\_\_

\_\_\_ Lonely images

\_\_\_\_\_

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     Naive     Suicidal ideas    \_\_\_\_\_
- Loyal     Considerate     Honest     Persevering    \_\_\_\_\_
- Trustworthy     Deviant     Incompetent     Good sense of humor
- 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 circle the number that most accurately reflects your opinions:

	<i>Strongly disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly agree</i>
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—the right way and the wrong way.	1	2	3	4	5
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 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.

<b>BEHAVIORS:</b>	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
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<b>FEELINGS:</b>	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
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<b>PHYSICAL SENSATIONS:</b>	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
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<b>MENTAL IMAGES:</b>	How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is "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
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<b>THOUGHTS:</b>	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
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<b>INTERPERSONAL RELATIONSHIPS:</b>	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
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<b>BIOLOGICAL FACTORS:</b>	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
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**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 too much					
Firful sleep					
Early morning awakening					
Earaches					
Headaches					
Backaches					
Bruise or bleed easily					
Weight problems					
Others:					

