LIFE HISTORY QUESTIONNAIRE

Purpose of this questionnaire:

The purpose of this questionnaire is to obtain a comprehensive picture of your background. You are requested to answer these routine questions in order to help us know you better.

It is understandable that you might be concerned about what happens to this information about you because this is highly personal. Case records are kept strictly confidential. **No outsider, not even your closest relative or family doctor, is permitted to see your case record without your written permission.**

I. General Information:

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Religion: _____ Attendance: Regular Sometimes Never
(circle one)

Whom do you live with now? (*List names, relationship, and ages*)

How strongly do you want treatment for your problem? (circle one)

Very Much Much Somewhat Could do without, if necessary

When you called House of Restoration Lay Counselors, did you already know who you wanted to be your lay counselor? Yes _____ No _____

Who referred you to House of Restoration: _____

II. Clinical

You can help us save time by explaining, in your own words, some things about your problem. Please be as specific as possible. A few specific examples of how the problem comes up would be valuable.

1. What is your chief concern? _____

_____

_____

_____

_____

_____

2. How often does it happen? _____

_____

_____

3. What would you like to happen? _____

_____

_____

_____

4. Have you talked about this with anyone else? Yes _____ No _____

If yes, who have you talked to? _____

Did they help you? Yes _____ No _____

If yes, how did they help? _____

_____

_____

_____

_____

III. Developmental Information:

Birth date: _____ Place of birth: _____

When you were young, how often did your family move? _____

How old were you when you left home? _____

Childhood Information:

1. What was your mother's condition during pregnancy (as far as you know)? _____
2. Check any of the following that apply to your childhood:

Night terrors _____ Bed wetting _____ Sleep walking _____

Thumb sucking _____ Nail biting _____ Stammering _____

Fears _____ Happy Childhood _____ Unhappy Childhood _____

Health:

1. Health during childhood: _____
2. Childhood illnesses: _____
3. Health during adolescence: _____
4. Adolescent illnesses: _____
5. Any physical disabilities: _____

   Are these related to your present problem? _____ If yes, how: _____

   _____

6. Any surgical operations: (Please list and at what age they occurred)

   _____

   _____

   _____

7. When was the last time you felt well, both physically and emotionally, for a fair amount of time?

   _____

   _____

   _____

8. Your present height: _____ Weight: _____

IV. Behaviors:

Please check any of the following behaviors that apply to you:

_____ Overeating	_____ Can't keep a job	_____ Suicide attempts
_____ Take drugs	_____ Compulsions	_____ Insomnia
_____ Vomiting	_____ Smoke	_____ Take too many risks
_____ Odd behavior	_____ Withdrawal	_____ Lazy
_____ Drink too much	_____ Nervous tics	_____ Eating problems
_____ Work too hard	_____ Concentration Difficulties	_____ Aggressive behavior
_____ Procrastination	_____ Sleep disturbance	_____ Crying
_____ Impulsive reactions	_____ Phobic avoidance	_____ Outbursts of temper
_____ Loss of control		

V. Feelings:

Please check any of the feelings that often apply to you:

_____ Angry	_____ Guilty	_____ Unhappy	_____ Annoyed
_____ Happy	_____ Bored	_____ Sad	_____ Conflicted
_____ Restless	_____ Depressed	_____ Regretful	_____ Lonely
_____ Anxious	_____ Hopeless	_____ Contented	_____ Fearful
_____ Hopeful	_____ Excited	_____ Panicky	_____ Helpless
_____ Optimistic	_____ Energetic	_____ Relaxed	_____ Tense
_____ Envious	_____ Jealous	Other: _____	

List your 5 main fears:

1. _____

2. _____

3. _____

4. _____

5. _____

VI. Physical Sensations:

Please check any of the following that often apply to you:

_____ Headaches	_____ Stomach trouble	_____ Skin problems	_____ Dizziness
_____ Chest pain	_____ Dry mouth	_____ Palpitations	_____ Fatigue
_____ Burning or itchy skin	_____ Muscle spasms	_____ Twitches	_____ Tics
_____ Sexual disturbances	_____ Rapid heart beat	_____ Back pain	_____ Tremors
_____ Don't like to be touched	_____ Unable to relax	_____ Tension	_____ Blackouts
_____ Fainting spells	_____ Hear things	_____ Watery eyes	_____ Flushes
_____ Bowel disturbances	_____ Excessive sweating	_____ Numbness	_____ Tingling
_____ Visual disturbances	_____ Hearing problems		

Have you ever been somewhere and can't remember how you got there? ____ Yes ____ No

Has there ever been a moment that you feel that you "lost time"? ____ Yes ____ No

If there is anything else we should know, please tell us:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Non-Christian Spiritual Experience Inventory

Please check any of the following activities in which you have been involved in any way.

OCCULT	CULT	OTHER RELIGIONS
Astral projection	Christian Science	Zen Buddhism
Ouija board	Unity	Hare Krishna
Table lifting	Scientology	Bahaism
Speaking in a trance	The Way International	Rosicrucianism
Automatic writing	Unification Church	Science of Mind
Visionary dreams	Church of the Living Word	Science of Creative Intelligence
Telepathy	Mormonism	Hinduism
Ghosts	Jehovah's Witnesses	Transcendentalism (Meditation)
Materialization	Children of God	Yoga
Clairvoyance	Swedenborgianism	Eckankar
Clairsentience	H.W. Armstrong (Worldwide Church of God)	Roy Masters
Fortune-telling	Unitarianism	Silva Mind Control
Tarot cards	Masons	Father Divine
Palm-reading	New Age	Theosophical Society
Astrology	Other	Islam
Rod & pendulum (dowsing)		Black Muslim
Amateur hypnosis		Other
Healing magnetism		
Magic charming		
Mental suggestion		
Black & white magic		
Blood pacts		
Fetishism		
Incubi & succubi (sexual parts)		

1. Have you ever attended a New Age seminar or participated in a séance? ___ Yes ___ No

2. Have you ever taken a class or read books on parapsychology? ___ Yes ___ No

If yes, explain: _____

_____

3. Have you ever heard voices in your mind or had repeating and nagging thoughts that were foreign to what you believe or feel? (As if there was a dialogue going on in your head)
Explain:_____

_____

4. What other spiritual experience have you had that would be considered out of the ordinary? _____

_____

_____