LIFE HISTORY FORM

"You will know the truth
And the truth will set you free." John 8: 32

Please read through this entire form before you begin to complete it.
Thank You.

Home Office:
2514 E. Pacific Ave.
Spokane, WA 99202 USA
Phone: (509) 475-5378
E-mail: jeff@genuinehealing.today

Counselor's Name: _____

First appointment date: ____/_____/_____

First appointment time: ____:____ to____:____ A.M./ P.M.

PURPOSE The purpose of this life history is to obtain a comprehensive picture of your background. Please complete the form as fully and accurately as you can by yourself. If the completed life history is received before your actual appointment and reviewed by those who will be counseling you, you will facilitate your counseling program by saving time and expense. Your counselors keep this record strictly confidential, and the information is not available to anyone without **your written permission**.
(* Children or clients that are unable to read or write may be asked these questions by an adult and have the answers written out for them.)

INTERNS: An intern may be present during your sessions. Would you prefer ❑ Male or ❑ Female? ❑ No preference
Please note. For safety or other considerations, your Counselor may require the participation of an intercessor and/or support person.

TODAY'S DATE: _____/_____/_____ **By what name would you like to be called?**_____

NAME _____ **PHONE (home):** (_____)_____/_____
FIRST **MIDDLE** **LAST** **PHONE (work):** (_____)_____/_____
STREET ADDRESS _____ **Apt:** _____ **May we call you at work?** ❑ **Yes** ❑ **No**
FAX: (_____)_____/_____
MAILING ADDRESS _____ **E-MAIL**: _____

CITY _____ **STATE/PROV.**_____
AGE:_____**BIRTH DATE**:____/____/_____
COUNTRY _____ **ZIP/POSTAL CODE**_____-_____ **SOCIAL SECURITY #**_____-____ -_____

Emergency contact person (other than spouse)_____ **PHONE (home):** (_____)_____/_____
RELATIONSHIP _____ **PHONE (work):** (_____)_____/_____
STREET ADDRESS _____**Apt #**_____

CITY _____ **STATE/PROV** _____ **COUNTRY** _____ **ZIP/POSTAL CODE** _____

Are you or were you in military service: ❑ Yes ❑ No If yes, which branch of military? _____
Religion/Denomination: _____ Place of Worship: _____
Worship Attendance (check one): ❑ Regular ❑ Occasional ❑ Not at All
I learned about or was referred to Genuine Healing Counseling Ministry by: _____
I requested my counselor by name: ❑ Yes ❑ No
How strongly do your want help to resolve issues in your life? (Check one) ❑ Very much ❑ Moderately ❑ Could do without
I have talked about these issues with:

	Psychiatrist (M.D.)	Psychologist (Ph.D.)	Other Professional	Lay Counselors	Pastoral
Type of Counseling					
Number of Hours					

NEED FOR COUNSELING

State in your own words the nature of your concern.

If your problem is something that you think happens too often, state approximately how often it occurs, how long it lasts and any other information you feel might be helpful in understanding your problem.

If your problem concerns something that's not happening as often as you would like, state what you would like to see happen more often, how often you think it should occur, etc.

If you have had previous counseling for this problem, state with whom and describe the outcome.

YOUR DESIRES

How do you hope to use your healing to bless others?

BEGINNINGS

Place a check mark in each box that apply to you or write the facts as they pertain to each item.

Place of Birth: _____ Weight at Birth: _____ pounds _____ounces _____

I was born: ❒ On time ❒ Late: How late? _____ ❒ premature: How premature? _____

❒ Delivered Cesarean Section

❒ I was a wanted baby. ❒ I was unwanted. How do you know?_____

_____

❒ I was adopted _____ ❒ days ❒ weeks ❒ months ❒ years after being born

❒ Birth mother and natural father were married to each other before my conception

❒ Birth mother and natural father were not happily married during my time in the womb

❒ Natural father was gone much of the time while I was in the womb

❒ Medications or forceps had to be used for my delivery

❒ Birth mother and /or natural father were grieving the loss or potential loss of a loved one during my womb life

❒ Birth mother experienced a previous miscarriage or abortion before I was conceived

❒ Birth mother had a difficult previous pregnancy

❒ Birth mother had a difficult pregnancy with me. What made it difficult?

_____

_____

❒ Birth mother and natural father were struggling with difficulties of life while I was in the womb. If yes, what were they:

What is the story your family tells about your coming into the world?

What significant events occurred in your early childhood?

List the number of "moves" you made in your first 18 years of life.

Age:	From:	To:	Reason:

HEALTH INFORMATION

Your present height: _____ weight: _____

List the number of hospitalizations or serious injuries you experienced in your first 18 years.

Incident:	Age Occurred:	Present Effects:

How do any of these health-related issues relate to your present problem?

List all prescription and non-prescription drugs you now take (include dosage):

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

EDUCATIONAL HISTORY

School/College/University	**Major/Degree**	**Date Received:**

Were you ever bullied or given a nickname? If yes, by whom and why?

Do you make friends easily? Do you keep them?

EMPLOYMENT HISTORY (List from most recent to oldest)

Job	**Type of work**	**Age**	**Left Because:**
1st			
2nd			
3rd			
4th			
5th			
6th			
7th			

How much money do you and your spouse earn?_____ Are you satisfied? ❒ Yes ❒ No

Do you enjoy your present job? ❒ Yes ❒ No If No, why?

What are your ambitions and aspirations?

SEX INFORMATION

What was the attitude towards sex in the home in which you grew up?

At what age did you derive your knowledge of sex? _____

How was it discussed or instructed?

How did you first learn about sex?

When did you become aware of your sexual impulses? What happened?

Did you ever have any anxieties or guilt feelings or trauma arising out of:

- Masturbation? If yes, please explain:

- Sexual Experience with the opposite sex? If yes, please explain:

- Sexual Experience with the same sex (homosexuality)? If yes, please explain:

Did anyone ever touch you in an inappropriately sexual way? If yes, please explain:

Menstrual History Age of first period: _____
Were you informed, or did it come as a shock?
How did others respond to you?

Are you regular? ❒ Yes ❒ No Duration: _____
Do you have pain? ❒ Yes ❒ No
Do your periods affect your moods? How?

Are there any questions, concerns and/or events you have about sex, sexual experiences and/or sexual identity past/present or future?

FAMILY DATA

Please be prepared to complete a Genogram as one of your assignments during your time at Genuine Healing. A Genogram is a brief history of your family tree, consisting of the names of your parents and your parents' parents, their experiences, key events, problems, religious practices, stories, etc.

List all of your brothers and sisters form oldest to youngest, including yourself. Please list in birth order, including any miscarriages, or abortions of which you know.

Name	Sex	Age	Marital Status	Job	Brief Description
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				

What was the relationship to your brothers and sisters in the past and why?

What is the relationship to you brothers and sisters in now in the present and why?

Which brother or sister is most like you, and in what respect?

Which brother or sister is most different from you, and in what respect?

Who played together and why?

Please list friends who are most important to you

(Family Data continued)
Have you ever lived with anyone other than your parents? ❑ Yes ❑ No
If yes, how old were you? _____ How long? _____

With whom did you live? _____ Why?

As a child, in what ways were you punished or disciplined by your parents?

How would you describe the home atmosphere in which you grew up?

Were you able to confide in your parents? Why or why not?

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc? If yes, why?

List any fearful or distressing experiences not previously mentioned:

DESCRIBE YOUR PARENTS

Answers on this page describe the mother and father who took primary responsibility for rearing you. If either person is other than your biological (birth) parent, **please copy this page**, complete it for your birth parent/s and attach the page/s to this form.

FATHER's Current Age ____ Name:		**MOTHER's** Current Age ____ Name:
Occupation before retiring:		
If deceased, what was the cause of death and their age? What was your age?		
	Personality	
	Values	
	Kind of home environment he/she provided	
	Relationship to each other	
	Who was in charge - real head of house	
	Relationship to the children	
	How he/she showed Love	
	Ambition for the Children	
	Ability to confide in him/her	

(Continued) FATHER		MOTHER
	Form of punishment he/she used	
	As a child, what I liked about him/her	
	As a child, what I disliked about him/her	
	His/her favorite child and why	
	Child most like Him/her	
	Child most different from him/her	
	Attitude towards sex	
	Had a problem with addictions or immorality	

Circle the number which best describes your opinion of the home in which you grew up.

	Too Permissive	Permissive	Average	Strict	Too Strict
Church attendance	5	4	3	2	1
Clothing	5	4	3	2	1
Computer use	5	4	3	2	1
Dating	5	4	3	2	1
Drinking alcohol	5	4	3	2	1
Free will	5	4	3	2	1
Home chores	5	4	3	2	1
Literature	5	4	3	2	1
Movies	5	4	3	2	1
Music	5	4	3	2	1
School work	5	4	3	2	1
Sex	5	4	3	2	1
Smoking	5	4	3	2	1
Television	5	4	3	2	1

MARITAL INFORMATION

	Name of Spouse	Length of Engagement	Age when Married		Length of Marriage	Reason Why It Ended	# of Children from that Marriage
			You	Spouse			
1st Marriage							
2nd Marriage							
3rd Marriage							
4th Marriage							

PRESENT MARRIAGE Anniversary Date: _____

What I liked the first few years:

What my spouse liked the first few years:

What I disliked the first few years:

What my spouse disliked the first few years:

What I have liked/disliked in the last few months:

What my spouse has liked/disliked in the last few months:

Place the letter "C" or "I" in each blank below as it applies to your present marriage.

C = Most Compatible I = Incompatible

_____ value system	_____ commitment to God	_____ devotion to spouse	_____ devotion to spouse
_____ intellect	_____ sleep requirements	_____ financial planning	_____ child discipline
_____ energy level	_____ food appetite	_____ spending money	_____ devotion to work
_____ social time	_____ exercise needs	_____ parenting style	_____ household duties
_____ planning	_____ sexual needs	_____ recreational interests	_____ in-law relationships
_____ goals	_____ need for touch	_____ educational preparation	_____ hobbies
_____ neatness	_____ need for time alone	_____ sensitivity to feelings	_____ Other _____
_____ friends	_____ conversation	_____ spiritual growth	_____ Other _____

(Present Marriage continued)
Give three specific examples of those things you would like to see your spouse do more often (e.g., take out the garbage, bring you a cup of coffee, spend more time with you, etc.)

Give three specific examples of those things you would like to see your spouse stop doing (three particular things that irritate you.):

List the names of your children, from oldest to youngest. Check if any of these children are from previous marriages (PM), or adopted, (AD). Also, as you list in order of birth, include any miscarriages or abortions.

Name	Sex	Age	PM	AD	Marital Status	Job	Brief Description
	M/F						
	M/F						
	M/F						
	M/F						
	M/F						
	M/F						

PREVIOUS MARRIAGE

What I liked about them:

What I disliked about them:

What my previous spouse(s) liked about me:

What my previous spouse/s disliked about me:

What ended the relationship(s)?

PERSONAL AND FAMILY HEALTH

Please place a check mark (✓) beside each listed item as it applies to you: S = self or your family: F = family.

S	F		S	F		S	F		S	F		S	F	
		inadequate			jaundice			alcoholism			guilt feelings			blood pressure problems
		anemia			abortions			smoker			miscarriages			P.M.S.
		allergies			asthma			shyness			fear of knives			suicidal thoughts
		lonely			flee worship			fantasy			wish born another time			blasphemous thoughts
		perfectionist			fear failure			drug abuse			thumb sucking			suicide
		generous			ambitious			gambling			DES baby			feel ripped off
		dependent			pleaser			obsessive			dislike confrontation			financial problems
		unworthy			diarrhea			unable to relax			difficulty deciding			rheumatic fever
		constipation			underweight			anorexia			peacemaker			excessive exercise
		bulimia			secretive			compulsive			angry			arrested for crime
		obesity			body image worry			cravings			insecurity			lustful thoughts
		controlling			moody			sexual addiction			pornography			hepatitis [A][B]
		bedwetting			masturbation			venereal disease			bladder infections			bowel disturbances
		stammering			nail biting			panic attacks			flashbacks			sleepwalking
		forgetful			intelligent			gifted [arts]			dizziness			unexplained muscle pain
		headaches			double vision			TMJ			blurred vision			accused of lying
		insomnia			suggestible			homosexuality			strange sensations			fibromyalgia
		voice changes			daydream			hear voices			convulsions			uneven achievement in school
		blood diseases			hearing problems			time conscious			shaking/tremors			thyroid problems
		doubts			lost interest			worry			scars			orthopedic problems
		sinus problems			autism			grief			cancer			breathing problems
		depression			fatigue			heart disease			kidney problems			liver problems
		feel tense			stomach trouble			feel panic			paralysis			fear going to hell
		cold sores			nightmares			sexual problems			sees God as distant			poor work performance
		difficult to pray			low energy			frustration			bad home conditions			sees God as harsh
		low energy			easily annoyed			fear success			martyr			difficult to read Bible
		fear God			feel inferior			difficulty deciding			spiritual abuse			unable to hold boundaries
		verbal abuse			emotional abuse			mental retardation			fear travel			bad reaction to anesthetics
		arthritis			bitter			bullied as child			lack common sense			hard to tell right from wrong
		feel invisible			physical abuse			skin diseases			narcolepsy			difficulty deciding what to wear
		diabetes			brain injury			sees life as good			can't express feelings			fear losing mind
		infertility			learning disability			sees life as bad			flooded by feelings			fear will hurt others
		mental illness			dread weekends			not listened to			unhappy childhood			fear terminal illness
		dread vacations			dread holidays			happy childhood			tuberculosis			see moving shadows

SPIRITUAL EXPERIENCES

Please place a check mark beside each item in which you or your family members have participated. Key: S = self F = family

S	F		S	F		S	F	
		Islam			Masons (Freemasonry)			astral-projection
		Wicca			Christian Science			astrology
		Bahaism			Children of God			automatic writing
		EST			Church of the Living Word			black magic/ white magic
		Echkankar			Cult of Diana			blood pacts
		Father Divine			Herbert W. Armstrong			clairvoyance
		Hare Krishna			(Radio Church of God)			dowsing (water witching)
		Hinduism			Jehovah Witness			fetishism
		Science of Creative Intelligence			Scientology			fortune telling
		Rosicrucian			Mormonism			ghosts
		Roy Masters			New Age			healing magnetism
		Science of the Mind			Swedenborgianism			hypnosis
		Silva Mind Control			The Local Church			incubi or succubae (sex spirits)
		Theosophical Society			The Way International			magic charming
		Transcendental Meditation			Unification Church			materialization
		Yoga			Unitarianism			mental suggestions
		Zen Buddhism			Unity			ouija board
		Satanism			Witchcraft			palm reading
		Other: _____			Other: _____			pendulum & rod
		Other: _____			Other: _____			spells
								reading tea leaves, etc.
								séance
								tarot cards
								telekinesis (i.e., table lifting)
								telepathy
								trance speaking
								visionary dreams
								drugs

How have any of the items you checked affected your life?

SELF-DESCRIPTION

In what situations do you lose control?

In what situations do you maintain self-control?

How do you believe you would be described by:

- Your spouse:
- Your best friend:
- Your worst enemy (even if you don't really have one):
- Yourself:

COMPLETE THE FOLLOWING SENTENCES

1) As a child, I . . .

2) For me, school was . . .

3) My childhood fears were . . .

4) My childhood ambitions were . . .

5) My role in my group of friends was . . .

6) The significant events in my physical and sexual development were . . .

7) The significant events in my social development were . . .

8) The most important values in my family were . . .

9) What stands out the most for me about my family life is . . .

10) My parents' relationship to each other was . . .

11) My brother' and sister' relationships to Dad were . . .

12) My brother' and sister' relationships to Mother were . . .