Health and Lifestyle Assessment

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InnerWisdom, Inc.
ASSESSMENT AND QUESTIONNAIRE

DIRECTIONS

This Assessment Questionnaire is meant to help you review nearly every aspect of your life. It was compiled in accordance with the holistic methodology that allows each individual to take stock of their life from many perspectives. Please complete the following questionnaire by answering **ALL** questions to the best of your ability. It is important to be as honest as possible when answering each question. Be sure to give a brief explanation to specific questions, when applicable. Not all of the questions in this assessment will pertain to you. If they do not, identify those questions by answering Not Applicable (N/A).

It is important that this questionnaire be completed as fully as possible before you begin the workbook chapters. If you are working with a therapist, counseling pastor, or other healthcare professional, **they can review the Assessment with you**. However, if it is too difficult, it is not necessary to share the information with others immediately. You may choose to wait for a time that better suits you.

SOCIAL HISTORY

Place of Birth: _____ Date of Birth: _____ Age: _____

Race/ethnicity - **check one**:

- ☐ Caucasian
- ☐ African American
- ☐ Native American
- ☐ Hispanic/Mexican Descent
- ☐ Asian
- ☐ Other_____

Reason for seeking life changes: _____

Length of time you have experience problems? _____

Date(s) of hospitalization for this condition (if any)? _____

Define and discuss problems of social development; adjustment to life situations [i.e. school, peer groups, community, family relationships, response to authority figures, use of leisure time]:

Cultural influences; ethnic factors which may be significant: _____

EDUCATION:

Please circle the last year of school that you completed:

1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20 21
Grade School	**High School**	**College**	**Master's Doctorate**

High School attended:	
College attended:	Major:
College attended:	Major:

My grades were/are:

- ☐ Excellent
- ☐ Above average
- ☐ About average
- ☐ Below Average

Approximate Grade Point Average:

High School _____

College _____

Attitude towards school and teachers? _____

_____

Extra Curricular Activities:

- ☐ Band/Choir
- ☐ Theater Arts
- ☐ Creative Arts
- ☐ Class Officer
- ☐ Sports
- ☐ Other

Did you leave home to attend college?

- ☐ No
- ☐ Yes

If yes, at what age? _____

FAMILY OF ORIGIN:

Is your father living?

☐ No If no, year of death: _____ His age at time of death: _____

If no, cause of death: _____

If no, your age at the time of his death: _____

☐ Yes If yes, how old is he now? _____

Describe your father's occupation when you were growing up: _____

Circle the last year of school that your father completed:

1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20 21
Grade School	**High School**	**College**	**Master's Doctorate**

When you were growing up was your father a/an:

- ☐ Alcohol or drug addict/abuser
- ☐ Food addict/abuser
- ☐ Physical/sex/other abuser
- ☐ Prescription drug addict/abuser

Describe your father's personality and his attitude towards you as you were growing up.

How would you describe your relationship with your father now? **Skip if deceased.**

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Below average
- ☐ Poor

Is your mother living?

☐ No If no, year of death: _____ Age: _____

If no, cause of death: _____

If no, your age at the time of her death: _____

☐ Yes If yes, how old is she now? _____

Describe your mother's occupation when you were growing up: _____

Circle the last year of school that your mother completed:

1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20 21
Grade School	**High School**	**College**	**Master's Doctorate**

When you were growing up was your mother a/an:

- ☐ Alcohol or drug addict/abuser
- ☐ Physical/sexual/other /abuser
- ☐ Food addict/abuser
- ☐ Prescription drug addict/abuser

Give a description of your mother's personality and her attitude toward you as you were growing up.

How would you describe your relationship with your mother now? **Skip if deceased.**

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Below average
- ☐ Poor

How would you describe your family's attitude toward you when you were growing up? **Please explain**.

Were your parents ever separated or divorced?

☐ No
☐ Yes

If yes, how old were you at the time? _____

Please describe your home atmosphere as you were growing up. Mention state of compatibility between parents and between parents and children.

Who raised you as a child? _____

How many brothers and sisters do you have?

Brothers _____ living _____ deceased _____ cause of death _____
Sisters _____ living _____ deceased _____ cause of death _____

In the space below, please provide the information requested on each of your brothers and sisters.

1 = Severe problems; 2 = Many problems; 3 = About average; 4 = Some problems; 5 = Well adjusted

Sibling #	First Name	Age	Sex	Weight	Height	Description - **Circle ONE**				
Sibling 1						1	2	3	4	5
Sibling 2						1	2	3	4	5
Sibling 3						1	2	3	4	5
Sibling 4						1	2	3	4	5
Sibling 5						1	2	3	4	5
Sibling 6						1	2	3	4	5
Sibling 7						1	2	3	4	5
Sibling 8						1	2	3	4	5

PRESENT RELATIONSHIPS:

What is your usual living arrangement?

What is your present marital status?

☐ Living alone
☐ Living with partner
☐ Separated
☐ Living with a spouse
☐ Living with family; specify;
☐ Never married
☐ Living with others; specify:
☐ Living in a communal society; specify:

☐ Married
☐ Living with a roommate/partner
☐ Separated
☐ Divorced
☐ Widowed

Please provide the following information for each marriage:

Start Date		End Date	Name of Spouse	Reason for Termination [Death, Divorce, etc.]	Number of Children from this Marriage	Names of Children
	to					
	to					
	to					

Please answer the following questions about your spouse/partner. If not currently married, but previously married, answer the following questions about your former spouse/partner

Is/was your spouse employed?
☐ No
☐ Yes

When employed, what kind of work did your spouse do? _____

Please circle the last year of school that your spouse completed:

1 2 3 4 5 6 7 8 **Grade School** 9 10 11 12 **High School** 13 14 15 16 **College** 17 18 19 20 21 **Master's Doctorate**

SEXUALITY:

What was your parents' attitude about sex? _____

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

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

Have you ever thought you needed help for your sexual thoughts or behaviors?
☐ Yes ☐ No If yes, **please explain**: _____

Do you ever resort to sex to escape, relieve anxiety, or cope with stressful situations?
☐ Yes ☐ No If yes, **please explain**: _____

Have you ever been arrested for a sex related offense?
☐ Yes ☐ No If yes, **please explain**: _____

Have you noticed physical symptoms such as nausea, knot in your stomach, or hot flashes when approached sexually?
☐ Yes ☐ No If yes, **please explain**: _____

How old were you when you masturbated for the first time? _____ years old.
How old were you when you had an orgasm for the first time? _____ years old.
How old were you when you had sexual intercourse for the first time? _____ years old.

Did you ever have any anxiety or guilt feelings about masturbation or having sexual intercourse? If yes, **please explain**.

Have you been sexually abused or raped? If yes, **please explain**. By whom?

Have you been in recovery for sexual abuse? _____ How long? _____

Is your present sex life satisfactory? If not, **please explain**.

Have you ever had an abortion? ☐Yes ☐ No What age? _____ **Please explain**.

How many children do you have (including children from previous marriages whether they are living with you or not)?

sons _____ living _____ deceased _____
daughters _____ living _____ deceased _____

Please provide the information requested for your children.

1 = Severe problems; 2 = Many problems; 3 = Average; 4 = Some problems; 5 = Well adjusted

Child #	First Name	Age	Sex	Weight	Height	Description - **Circle ONE**				
Child 1						1	2	3	4	5
Child 2						1	2	3	4	5
Child 3						1	2	3	4	5
Child 4						1	2	3	4	5
Child 5						1	2	3	4	5
Child 6						1	2	3	4	5
Child 7						1	2	3	4	5
Child 8						1	2	3	4	5

VOCATION/EMPLOYMENT:

Are you employed?

☐ Yes

☐ No

Name of employer? _____

Briefly describe the kind of work you do. _____

_____

_____

How long have you done this kind of work? _____ years

Does your present work satisfy you? ☐ Yes ☐ No

If not, in what ways are you dissatisfied? _____

_____

What would you like to do? _____

_____

_____

What jobs have you held in the past? _____

_____

_____

What were your vocational ambitions in the past? _____

_____

_____

_____

What are your vocational ambitions now? _____

_____

_____

_____

_____

What is the total annual income of your family? **Check ONE**

- ☐ Under $12,000
- ☐ Between $12,000 and $20,000
- ☐ Between $20,000 and $35,000
- ☐ Between $35,000 and $60,000
- ☐ Over $60,000

☐

MILITARY HISTORY

Branch of Service?

Rank?

Type of Duty?

Length of Service?

Type of Discharge?

Adjustment to Military Life?

LEGAL DIFFICULTIES:

DUI? ☐ Yes ☐ No

If Yes, please explain and give dates. _____

Other difficulties including lawsuits, legal guardianship, custody of minor child(ren).

Additional legal difficulties: _____

RELIGION/SPIRITUALITY:

Do you believe in God? ☐ Yes ☐ No

In what religion were you raised?

- ☐ Catholic
- ☐ Jewish
- ☐ Protestant specify:
- ☐ Fundamental Protestant specify:
- ☐ Buddhist
- ☐ Muslim
- ☐ Hindu
- ☐ Agnostic
- ☐ No Religion
- ☐ Other specify: _____

Which describes best how your family that you grew up in practiced religion?

- ☐ Actively participated [went to church several times a week]
- ☐ Moderately participated [went to church once a week]
- ☐ Occasionally participated [went to church every once in a while]
- ☐ Rarely participated [only went on holy days such as Easter]
- ☐ Never participated [stated they believed in God but never went to church]
- ☐ My family of origin had no religion in which to participate

Which describes best how you feel about your religious upbringing?

- ☐ Religion was beaten into me
- ☐ Religion was a good experience
- ☐ I am angry about being forced to go to church
- ☐ I am grateful for my religious upbringing
- ☐ My religious upbringing is irrelevant to my life
- ☐ I have no particularly strong feelings about my religious upbringing

As a child, I understood God as being:

- ☐ Loving and generous
- ☐ Wrathful and angry
- ☐ Everywhere as in nature but powerless to help me
- ☐ Removed from my daily life
- ☐ Could not imagine God
- ☐ Wanted to believe in God but had difficulty
- ☐ God? Who cares?

As a child, my greatest religious concern was:

- ☐ Heaven and hell
- ☐ Guilt and punishment
- ☐ Love and grace
- ☐ Satan/the devil and evil
- ☐ Being good or being bad
- ☐ Fearful of God's punishment
- ☐ Death
- ☐ I had no religious concerns

How did your parents respond to your grief?

- ☐ They ignored it
- ☐ They helped me through it and comforted me
- ☐ They told me to stuff my feelings
- ☐ They got angry at my feelings
- ☐ They showed disgust at my feelings
- ☐ They did not see me or my feelings [I felt invisible]

Do you feel your faith or religion has been:

- ☐ A vital part of your life
- ☐ Important, but not vital
- ☐ Something you can take or leave
- ☐ The source of all your problems
- ☐ Have had no faith or religion as an adult

Please explain: _____

_____

_____

Now I understand God as being

- ☐ Loving and generous
- ☐ Wrathful and angry
- ☐ Everywhere as in nature but powerless to help me
- ☐ Removed from my daily life
- ☐ Can not imagine God
- ☐ Want to believe in God but have difficulty
- ☐ God? Who cares?

This is ☐ Similar to ☐ Different from my childhood belief.

Which of the following contributes to your inability to find peace of mind?

- ☐ Hopelessness
- ☐ Despair

☐ Depression
☐ Self-hate
☐ Lack of discipline
☐ Impatience
☐ Resentment
☐ Constant lying
☐ Sex issues
☐ Other specify: _____

Do you feel you have done something that is so bad you cannot be forgiven?

☐ Yes
☐ No

Please explain. _____

HOBBIES/INTERESTS:

What are your present interests, hobbies and activities? _____

How much time do you spend in leisure activities? _____

Do you prefer spending leisure time alone or with others? Why? _____

How is most of your leisure time occupied? _____

What would you like to change about your leisure time and the way it is spent? **Please explain**.

PSYCHIATRIC HISTORY:

Does anyone in your family have a psychiatric illness, such as depression, alcoholism, drug dependence or an eating disorder? **Please give details**.

Are there any other members of the family about whom information regarding illness, etc., is relevant?

List any situations that make you feel stressed. _____

_____

_____

List any situations, which make you feel calm or relaxed. _____

_____

_____

How were you referred to a treatment or self-help Program?

- ☐ Family member [relationship]: _____
- ☐ Physician [name]: _____
- ☐ Therapist [name]: _____
- ☐ Friend
- ☐ Clergy
- ☐ Internet
- ☐ Other specify: _____

Below, briefly state your expectations concerning a treatment or self-help Program. What benefits do you want to derive?

_____

_____

_____

_____

MEDICAL HISTORY:

What are your present medical problems? _____

_____

_____

_____

What are your past medical problems? _____

_____

_____

What medication or drugs are you taking? Please list names and amounts, including any for weight control and including birth control pills.

NAME OF MEDICATION OR DRUG	AMOUNT	HOW OFTEN	REASON

Are you allergic to any medication, drugs or foods?

- ☐ No

☐Yes If yes, please list which and what reaction you have; e.g. "rash".

When did you last have a complete physical exam?
Date [Month, Day, Year]: / /

Who is your current medical doctor? _____

ADDICTIONS HISTORY:

How much alcohol do you currently drink?
- ☐ One or more drinks daily
- ☐ Two or more drinks a week
- ☐ One drink a week
- ☐ One drink a month
- ☐ Less than one drink a month

In the past?
- ☐ One or more drinks daily
- ☐ Two or more drinks a week
- ☐ One drink a week
- ☐ One drink a month
- ☐ Less than one drink a month

Specify type(s) of alcohol: _____

Are you currently an
- ☐ Alcoholic
- ☐ Drug addict
- ☐ Prescription drug addict
- ☐ Food addict
- ☐ Recovering alcoholic
- ☐ Recovering drug addict
- ☐ Recovering prescription drug addict
- ☐ Recovering food addict

Please indicate your current use of drugs:

	None	Amount	Daily	Weekly	Monthly
Amphetamines					
Barbiturates					
Cocaine					
Heroin					
Hallucinogens					
Marijuana					
Tranquilizers					
Other					

Please indicate your past use of drugs:

	None	Amount	Daily	Weekly	Monthly
Amphetamines					
Barbiturates					
Cocaine					
Heroin					

Hallucinogens					
Marijuana					
Tranquilizers					
Other					

How many cigarettes do you currently smoke daily?
In the past?

- ☐ Three packs or more
- ☐ Between one and three packs
- ☐ One to three packs
- ☐ Less than one pack
- ☐ Three packs or more

How long have you smoked? _____

How many cups of coffee do you drink daily?

- ☐ Six cups or more
- ☐ Three to five cups
- ☐ One or two cups
- ☐ None

How many cups of soda do you drink daily?

- ☐ Six cans or more
- ☐ Three to five cans
- ☐ One or two cans
- ☐ None

Are they "diet" sodas? ☐ Yes ☐ No
Are they caffeine free? ☐ Yes ☐ No

How many hours of sleep do you need to feel your best?

- ☐ Ten hours or more
- ☐ Eight to ten hours
- ☐ Six to eight hours
- ☐ Less than six hours

Check one:

- ☐ I get enough sleep.
- ☐ I do not get enough sleep.
- ☐ I sleep too much

How would you describe your overall physical health? **Check one**

- ☐ Excellent
- ☐ Better than average
- ☐ Average
- ☐ Worse than average
- ☐ Poor

List health problems or symptoms: _____

_____

MENSTRUAL HISTORY: [MALES SKIP]

How old were you when your first menstrual period began? _____ years old

☐ Not Applicable [for females who have never menstruated]

Are you on birth control?

☐ Yes
☐ No

How many times have you missed your period for 2 consecutive months or more (excluding pregnancy)?

_____ Times ☐ Never

Please complete the following for each time your menstrual period stopped:

	Most Recently	Previous Time	Previous Time	Previous Time
Date				
Weight				
Date resumed				
Weight resumed				

EXCEPT for any times when your periods may have stopped because of a major weight loss or gain, what is the approximate regularity of your periods?

☐ Fairly regular [same number of days, not more than 3 days early, late]
☐ Somewhat irregular [within 4 to 10 days early or late]
☐ Very irregular [more than 10 days early or late]

PRIOR HEALTH HISTORY:

NOT COUNTING HOSPITALIZATION FOR CHILDBIRTH, please list all hospitalizations, indicating your age and the reason for each admission:

AGE	**REASON FOR HOSPITALIZATION**

Please list any serious illnesses you have had which DID NOT REQUIRE HOSPITALIZATION:

AGE	**ILLNESS**

Have you ever received psychiatric therapy or are you now receiving psychiatric therapy?

☐ No, never
☐ Yes, in the past. Why? _____

_____

_____

_____

☐ Yes, at present. Why? _____

_____

_____

Please complete the section below regarding your psychiatric therapy.

Age	Reason for Contact	Type of Therapy Received	Length of Treatment

ATTITUDE TOWARD PRESENT LIFE SITUATION:

Please check the following responses that apply to you:

☐ take sedatives
☐ feel panicky
☐ suicidal ideas
☐ sexual problems
☐ inferiority feelings
☐ over-ambitious
☐ shy with people
☐ unable to have a good time
☐ can't make decisions
☐ home conditions bad
☐ concentration difficulties
☐ don't like weekends & vacations
☐ headaches
☐ palpitations
☐ bowel disturbances
☐ nightmares
☐ feeling tense
☐ depressed
☐ eat too much
☐ dizziness
☐ stomach trouble
☐ fatigue
☐ can't make friends
☐ can't keep a job
☐ financial problems
☐ unable to relax
☐ fainting spells
☐ no appetite
☐ insomnia
☐ alcoholism
☐ tremors
☐ take drugs
☐ memory problems

Others: _____

Check the following words, which apply to you:

☐worthless	☐full of regrets	☐unassertive	☐intelligent
☐inadequate	☐hostile	☐deformed	☐confident
☐can't do anything right	☐cowardly	☐unloved	☐misunderstood
☐horrible thoughts	☐ugly	☐worthwhile	☐unconfident
☐guilty	☐lonely	☐life is empty	☐sympathetic
☐agitated	☐attractive	☐naive	☐anxious
☐repulsive	☐a "nobody"	☐morally wrong	☐panicky
☐confused	☐incompetent	☐considerate	☐unattractive
☐useless	☐evil	☐bored	☐restless
☐stupid	☐full of hate	☐in conflict	☐fat

Others: _____

DO YOU HAVE A HISTORY OF:

	Yes	No		Yes	No
Heart Disorders	☐	☐	Diabetes	☐	☐
Asthma/Emphysema	☐	☐	Cancer	☐	☐
Other Lung Disorders	☐	☐	Aids/HIV	☐	☐
High Blood Pressure	☐	☐	Any Implants	☐	☐
Rheumatoid Arthritis	☐	☐	Broken Bones	☐	☐
Stress Related Tension	☐	☐	Back Problems	☐	☐
Circulatory Disorders	☐	☐	Neck Problems	☐	☐
Migraine Headaches	☐	☐	Recent Fever	☐	☐
Tension Headaches	☐	☐	Recent Pain	☐	☐
Recent Infections	☐	☐	Chronic Pain	☐	☐
Psychological Disorder	☐	☐	Blood Clots	☐	☐
Kidney Disorders	☐	☐	TMJ Problems	☐	☐
Nervous Disorders	☐	☐	Numbness	☐	☐
Sinus Problems	☐	☐	Dizziness	☐	☐
Skin Allergies	☐	☐	Edema	☐	☐
Gastrointestinal Disturbances	☐	☐	Respiratory Allergies	☐	☐
Fluid Retention	☐	☐	Loss of smell	☐	☐
Hay fever	☐	☐	Loss of taste	☐	☐
Tightness of throat	☐	☐	Inflammation/throat	☐	☐
Thyroid trouble	☐	☐	Face Flushed	☐	☐
Twitching of face	☐	☐	Loss of memory	☐	☐
Fatigue	☐	☐	Depression	☐	☐
Head feels heavy	☐	☐	Fainting	☐	☐
Loss of balance	☐	☐	Ringing in ears	☐	☐
Light bother eyes	☐	☐	Grating in neck	☐	☐
Tightness of shoulder muscles	☐	☐	Neuritis in shoulder & arms	☐	☐
Pins & needles in arms & hands	☐	☐	Cold hands	☐	☐
Chest pains	☐	☐	Seizures	☐	☐
Shortness of breath	☐	☐	T.B	☐	☐
Heart palpitation	☐	☐	Heart attacks	☐	☐
High blood pressure	☐	☐	Low blood pressure	☐	☐
Anemia	☐	☐	Rheumatic fever	☐	☐
Nervous stomach	☐	☐	Stomach trouble	☐	☐
Ulcers	☐	☐	Irritability	☐	☐
Cold sweats	☐	☐	Liver trouble	☐	☐
Gall bladder trouble	☐	☐	Indigestion	☐	☐
Constipation	☐	☐	Bladder trouble	☐	☐
Sleeping problems	☐	☐	Swollen joints	☐	☐
Pins & needles in legs	☐	☐	Cold feet	☐	☐
Pains in legs & feet	☐	☐	Phlebitis	☐	☐

Varicose veins	☐	☐	Shoulder pain	☐	☐
Knee pain	☐	☐	Weight control	☐	☐
Stress	☐	☐	Post stroke symptoms	☐	☐
Hormone balance	☐	☐	Energy build-up	☐	☐
Stimulation of hair growth	☐	☐	Insomnia	☐	☐
Hepatitis	☐	☐	G.I. Problems	☐	☐
Urinary problems	☐	☐	Muscular/Skeletal	☐	☐
Venereal disease	☐	☐	Epileptic	☐	☐
Sensitive to touch/in any area	☐	☐	Wear contact lenses	☐	☐

MALES ONLY:

- ☐ Prostate trouble
- ☐ Urination difficulty
- ☐ Frequent night urination
- ☐ Burning upon urination
- ☐ Persistent abdominal pain
- ☐ Pain on inside of legs or heels
- ☐ Pain in groin area
- ☐ Low back pain
- ☐ Tire too easily
- ☐ Lack of energy
- ☐ Excessive perspiration
- ☐ Diminished sex drive
- ☐ Burning or pain during orgasm

FEMALES ONLY:

- ☐ Easily fatigued
- ☐ Pre-menstrual stress
- ☐ Tension
- ☐ Depression
- ☐ Painful menstruation cramps
- ☐ Menstruation excessive & prolonged
- ☐ Menstruation scanty or missing
- ☐ Vaginal Discharge
- ☐ Painful breasts
- ☐ Menopausal hot flashes, etc.
- ☐ Melancholia of long standing
- ☐ I.U.D. diaphragm
- ☐ Birth control pills

Are you pregnant? _____ Last menstrual period _____

How many pregnancies? _____ Last pap Smear _____

Are you taking any of the following? Check those that apply

- ☐ Laxatives
- ☐ Aspirin
- ☐ Sleeping Pills
- ☐ Insulin
- ☐ Sedatives
- ☐ Vitamins
- ☐ Minerals
- ☐ Herbs
- ☐ Antidepressant
- ☐ Antihypertensive
- ☐ Medical Prescriptions (list all) _____

_____