



CHURCH

The Church
Pension Fund

LIFE HISTORY QUESTIONNAIRE*

Applicants for Holy Orders receive this questionnaire for self-examination and preparation for the mental health evaluation required by the Canons of the Episcopal Church. This completed, confidential document is conveyed by the applicant directly to the mental health professional(s) conducting the clinical examination in whose custody it exclusively remains.

The examiner's conclusions following clinical examination are based upon a wide variety of test and interview responses. No individual question in this document determines the outcome of the clinical interview. Rather, the LHQ serves as a comprehensive foundation for the structured clinical interview. The examiner's final impressions, based in part upon this document and the clinical interview, form the basis of the Required Mental Health Evaluation Report Summary.

*Like other parts of the discernment process, this evaluation addresses the impact of previous and current life issues upon one's readiness for ordained ministry. This document, combined with the clinical interview, provides the applicant with an opportunity to discuss personal life and vocational goals in context with one's life history. This document, once completed, remains a part of the clinician's file and is not delivered to the diocese.

DIRECTIONS: This questionnaire contains a series of items regarding your background, experiences, and beliefs. Please read each question carefully. For each question, write a response. For some items, you will be asked to write your answer in the space following each question. Other confidential questions will require you to check a response option for your answer.

Do not skip items.

If a question does not apply to you, write "*Does Not Apply*" or "*N/A.*"

Please use an *ink pen.*

If you need additional space for an answer, please use the blank pages at the end of this questionnaire.

IDENTIFYING INFORMATION

Name (Last, First, MI):

Today's Date:

Current Address:

Birthdate:

City, State, Zip:

Age:

Telephone Number(s):

SSN:

Sponsoring Diocese:

CURRENT LIFE STATUS

Social/Marital Status

1. What is your current marital status? (If separated or divorced, please complete all that apply.)

- Single
 Married Date: _____
 Remarried Date: _____
 Divorced Date: _____
 Separated Date: _____
 Other (describe): _____

2. With whom do you live at present? (Enter the names of all person(s) currently living with you, ages, and relationships.)

Name	Age	Relationship

3. Do you currently own or rent a home or condominium? Own Rent

Length of time at present address: _____

4. Do you or anyone in your family/household have any learning, medical, or emotional problems? Yes No
If "YES," what are your/their needs?

5. Describe your current social support system indicating who the most important people in your life are.

6. Generally speaking, how is your physical health **RIGHT NOW**? Mark your response using the list below:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Failing | <input type="checkbox"/> Average | <input type="checkbox"/> Excellent |
| <input type="checkbox"/> Very Poor | <input type="checkbox"/> Above Average | |
| <input type="checkbox"/> Poor | <input type="checkbox"/> Good | |
| <input type="checkbox"/> Below Average | <input type="checkbox"/> Very good | |

7. Are you currently under the care of a physician for any medical condition(s)? Yes No
 If "YES," please describe the condition(s) briefly:

8. Generally speaking, how is your mental health **RIGHT NOW**? Mark your response using the list below:

<input type="checkbox"/> Failing	<input type="checkbox"/> Average	<input type="checkbox"/> Excellent
<input type="checkbox"/> Very Poor	<input type="checkbox"/> Above Average	
<input type="checkbox"/> Poor	<input type="checkbox"/> Good	
<input type="checkbox"/> Below Average	<input type="checkbox"/> Very good	

9. Describe any present day life circumstances causing you distress including stressful life events and/or stressful roles.

10. Are you currently under the care of a mental health provider for any reason? Yes No
 If "YES," please describe briefly:

11. Review the following list of problems. Mark any problems that may pertain to you in the present, past, or both.

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Fears	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Shyness	<input type="checkbox"/>	<input type="checkbox"/>	Tiredness
<input type="checkbox"/>	<input type="checkbox"/>	Finances	<input type="checkbox"/>	<input type="checkbox"/>	Separation
<input type="checkbox"/>	<input type="checkbox"/>	Divorce	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use
<input type="checkbox"/>	<input type="checkbox"/>	Friends	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>	Unhappiness	<input type="checkbox"/>	<input type="checkbox"/>	Making Decisions
<input type="checkbox"/>	<input type="checkbox"/>	Self-control	<input type="checkbox"/>	<input type="checkbox"/>	Inhibited Sexual Desires
<input type="checkbox"/>	<input type="checkbox"/>	Ambition	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts
<input type="checkbox"/>	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	<input type="checkbox"/>	Concentration
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Stress
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Temper
<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Career Choices
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Relaxation
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Health Problems
<input type="checkbox"/>	<input type="checkbox"/>	Contraception	<input type="checkbox"/>	<input type="checkbox"/>	Marriage
<input type="checkbox"/>	<input type="checkbox"/>	Education	<input type="checkbox"/>	<input type="checkbox"/>	School
<input type="checkbox"/>	<input type="checkbox"/>	Parenting	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Children	<input type="checkbox"/>	<input type="checkbox"/>	Sadness
<input type="checkbox"/>	<input type="checkbox"/>	Work	<input type="checkbox"/>	<input type="checkbox"/>	Legal Matters
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	My Thoughts
<input type="checkbox"/>	<input type="checkbox"/>	Guilt Feelings	<input type="checkbox"/>	<input type="checkbox"/>	Energy (Increased or Decreased)
<input type="checkbox"/>	<input type="checkbox"/>	Relationships	<input type="checkbox"/>	<input type="checkbox"/>	Appetite (Increased or Decreased)
<input type="checkbox"/>	<input type="checkbox"/>	Crying Episodes	<input type="checkbox"/>	<input type="checkbox"/>	Intrusive or Unwanted Thoughts
<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	Decreased/Increased Sexual Interest
			<input type="checkbox"/>	<input type="checkbox"/>	Other
			<input type="checkbox"/>	<input type="checkbox"/>	Other

Add comments regarding any problems you may have marked above:

<p>12. What is your personal annual income from all sources?</p> <table border="0"> <tr> <td><input type="checkbox"/> Under \$15,000</td> <td><input type="checkbox"/> \$60,000 -- \$74,999</td> </tr> <tr> <td><input type="checkbox"/> \$15,000 -- \$24,999</td> <td><input type="checkbox"/> \$75,000 -- \$99,999</td> </tr> <tr> <td><input type="checkbox"/> \$25,000 -- \$39,999</td> <td><input type="checkbox"/> \$100,000 -- \$150,000</td> </tr> <tr> <td><input type="checkbox"/> \$40,000 -- \$49,999</td> <td><input type="checkbox"/> Over \$150,000 per year</td> </tr> <tr> <td><input type="checkbox"/> \$50,000 -- \$59,999</td> <td></td> </tr> </table>	<input type="checkbox"/> Under \$15,000	<input type="checkbox"/> \$60,000 -- \$74,999	<input type="checkbox"/> \$15,000 -- \$24,999	<input type="checkbox"/> \$75,000 -- \$99,999	<input type="checkbox"/> \$25,000 -- \$39,999	<input type="checkbox"/> \$100,000 -- \$150,000	<input type="checkbox"/> \$40,000 -- \$49,999	<input type="checkbox"/> Over \$150,000 per year	<input type="checkbox"/> \$50,000 -- \$59,999	
<input type="checkbox"/> Under \$15,000	<input type="checkbox"/> \$60,000 -- \$74,999									
<input type="checkbox"/> \$15,000 -- \$24,999	<input type="checkbox"/> \$75,000 -- \$99,999									
<input type="checkbox"/> \$25,000 -- \$39,999	<input type="checkbox"/> \$100,000 -- \$150,000									
<input type="checkbox"/> \$40,000 -- \$49,999	<input type="checkbox"/> Over \$150,000 per year									
<input type="checkbox"/> \$50,000 -- \$59,999										
<p>13. What is your current occupational status?</p> <p><input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Unemployed</p> <p>If "Employed," please complete the following</p> <p>Current Employer: _____</p> <p>Position Title: _____</p> <p>Date Hired: _____</p>										
<p>14. To whom are you responsible in your current position:</p> <p>Supervisor's Name: _____</p> <p>Title: _____</p>										
<p>15. Have you encountered any problems in this or prior professional relationships? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "YES," please describe:</p>										
<p>16. How have you asked for help within your present job?</p>										
<p>17. What kinds of people give you the most difficulty in your current position?</p>										
<p>18. Describe the type of work which you enjoy the most.</p>										
<p>19. Describe the type of work which you enjoy the least.</p>										

Family/Social/Developmental History

Father:

20. Father's Name: _____
Date of Birth: _____ Age: _____ (If deceased, complete Item 21,
otherwise go to Item 22.)
Ethnic Background: _____
Nature of Employment/Profession: _____

21. If your father is not alive, please answer the following questions:

a. Year of his death: _____ c. Your age at his death: _____
b. His age at death: _____ d. Cause of death: _____

22. I consider the following to have been true of my father while I was a child. (Mark all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Home very little, absent | <input type="checkbox"/> Home almost always, present |
| <input type="checkbox"/> Powerless, victim, target, helpless | <input type="checkbox"/> Powerful, capable, independent |
| <input type="checkbox"/> Sad, blue, pessimistic | <input type="checkbox"/> Optimistic, cheerful, hopeful |
| <input type="checkbox"/> Poorly read, uninformed | <input type="checkbox"/> Well-read, informed |
| <input type="checkbox"/> Uneducated | <input type="checkbox"/> Well-educated |
| <input type="checkbox"/> Thoughtless, shallow, superficial | <input type="checkbox"/> Thorough, substantial, thoughtful |
| <input type="checkbox"/> Inconsistent, easily upset, unstable | <input type="checkbox"/> Stable, calm, consistent |
| <input type="checkbox"/> Chaotic, unstable, unreliable | <input type="checkbox"/> Reliable, stable, orderly |
| <input type="checkbox"/> Closed, controlling | <input type="checkbox"/> Trusting, open |
| <input type="checkbox"/> Overly critical | <input type="checkbox"/> Esteem building or enhancing |
| <input type="checkbox"/> Rigid rules, restrictive | <input type="checkbox"/> Permissive, flexible rules |
| <input type="checkbox"/> Spanked, beat, hit, slapped, whipped | <input type="checkbox"/> Rarely disciplined physically |
| <input type="checkbox"/> Criticism, guilt, loss of love, shame | <input type="checkbox"/> Rarely disciplined emotionally |
| <input type="checkbox"/> Cold, distant, unavailable | <input type="checkbox"/> Available, warm, close |
| <input type="checkbox"/> Intrusive, disrespectful | <input type="checkbox"/> Respectful, considerate |
| <input type="checkbox"/> Critical, conditional | <input type="checkbox"/> Supportive, accepting |
| <input type="checkbox"/> Dishonest | <input type="checkbox"/> Especially honest |
| <input type="checkbox"/> Difficult for me to confide in | <input type="checkbox"/> Easy for me to confide in |
| <input type="checkbox"/> Difficult for me to respect | <input type="checkbox"/> Easy for me to respect |
| <input type="checkbox"/> Tense, worried, unsure | <input type="checkbox"/> Sure, secure, confident |
| <input type="checkbox"/> Passive, meek, timid | <input type="checkbox"/> Assertive, bold |
| <input type="checkbox"/> Self-centered, self-indulgent | <input type="checkbox"/> Generous, empathic |
| <input type="checkbox"/> In ill health or injured | <input type="checkbox"/> Always in good health |
| <input type="checkbox"/> Mis-used alcohol | <input type="checkbox"/> Drank none or very little |
| <input type="checkbox"/> Mis-used street drugs | <input type="checkbox"/> Used none or very little street drugs |
| <input type="checkbox"/> Mis-used medications | <input type="checkbox"/> Used medications only as prescribed |
- Legal problems: _____
 Employment problems: _____
 Financial problems: _____
 Fidelity problems: _____
 Sexual problems: _____
 Marital problems: _____
 Other problems: _____

23. What kind of person was your father?

24. Describe your relationship with your father:

25. Describe your earliest memory of your father:

26. Please describe any substitute paternal influences throughout childhood/adolescence (e.g., stepfather, adopted father, "surrogate" father).

Mother:

27. Mother's Name: _____

Date of Birth: _____ Age: _____ (If deceased, complete Item 28, otherwise go to Item 29.)

Ethnic Background: _____

Nature of Employment/Profession: _____

28. If your mother is not alive, please answer the following questions:

a. Year of her death: _____ c. Your age at her death: _____

b. Her age at death: _____ d. Cause of death: _____

29. I consider the following to have been true of my mother while I was a child. (Mark all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Home very little, absent | <input type="checkbox"/> Home almost always, present |
| <input type="checkbox"/> Powerless, victim, target, helpless | <input type="checkbox"/> Powerful, capable, independent |
| <input type="checkbox"/> Sad, blue, pessimistic | <input type="checkbox"/> Optimistic, cheerful, hopeful |
| <input type="checkbox"/> Poorly read, uninformed | <input type="checkbox"/> Well-read, informed |
| <input type="checkbox"/> Uneducated | <input type="checkbox"/> Well-educated |
| <input type="checkbox"/> Thoughtless, shallow, superficial | <input type="checkbox"/> Thorough, substantial, thoughtful |
| <input type="checkbox"/> Inconsistent, easily upset, unstable | <input type="checkbox"/> Stable, calm, consistent |
| <input type="checkbox"/> Chaotic, unstable, unreliable | <input type="checkbox"/> Reliable, stable, orderly |
| <input type="checkbox"/> Closed, controlling | <input type="checkbox"/> Trusting, open |
| <input type="checkbox"/> Overly critical | <input type="checkbox"/> Esteem building or enhancing |
| <input type="checkbox"/> Rigid rules, restrictive | <input type="checkbox"/> Permissive, flexible rules |
| <input type="checkbox"/> Spanked, beat, hit, slapped, whipped | <input type="checkbox"/> Rarely disciplined physically |
| <input type="checkbox"/> Criticism, guilt, loss of love, shame | <input type="checkbox"/> Rarely disciplined emotionally |
| <input type="checkbox"/> Cold, distant, unavailable | <input type="checkbox"/> Available, warm, close |
| <input type="checkbox"/> Intrusive, disrespectful | <input type="checkbox"/> Respectful, considerate |
| <input type="checkbox"/> Critical, conditional | <input type="checkbox"/> Supportive, accepting |
| <input type="checkbox"/> Dishonest | <input type="checkbox"/> Especially honest |
| <input type="checkbox"/> Difficult for me to confide in | <input type="checkbox"/> Easy for me to confide in |
| <input type="checkbox"/> Difficult for me to respect | <input type="checkbox"/> Easy for me to respect |
| <input type="checkbox"/> Tense, worried, unsure | <input type="checkbox"/> Sure, secure, confident |
| <input type="checkbox"/> Passive, meek, timid | <input type="checkbox"/> Assertive, bold |
| <input type="checkbox"/> Self-centered, self-indulgent | <input type="checkbox"/> Generous, empathic |
| <input type="checkbox"/> In ill health or injured | <input type="checkbox"/> Always in good health |
| <input type="checkbox"/> Mis-used alcohol | <input type="checkbox"/> Drank none or very little |
| <input type="checkbox"/> Mis-used street drugs | <input type="checkbox"/> Used none or very little street drugs |
| <input type="checkbox"/> Mis-used medications | <input type="checkbox"/> Used medications only as prescribed |
| <input type="checkbox"/> Legal problems: _____ | |
| <input type="checkbox"/> Employment problems: _____ | |
| <input type="checkbox"/> Financial problems: _____ | |
| <input type="checkbox"/> Fidelity problems: _____ | |
| <input type="checkbox"/> Sexual problems: _____ | |
| <input type="checkbox"/> Marital problems: _____ | |
| <input type="checkbox"/> Other problems: _____ | |
| _____ | |

30. What kind of person was your mother?

31. Describe your relationship with your mother:

32. Describe your earliest memory of your mother:

33. Please describe any substitute maternal influences throughout childhood/adolescence (e.g., stepmother, adopted mother, "surrogate" mother).

Marital Status of your Parents:

34. Are your parents married, separated, divorced, or widowed? If they are separated or divorced, please describe the circumstances, including when they were divorced or how long any separation(s) have been.

35. Describe the *current* nature of your parents' relationship to each other.

36. Describe your parents' relationship to each other *while you were growing up*.

37. Were you raised by your parents?

Yes No

If not, by whom were you raised?

Siblings

38. List all siblings from eldest to youngest (including any who may have died).

Sibling Name	Age/ Deceased	Current Location of Residence	Marital Status	Employment Status
a.				
b.				
c.				
d.				
e.				
f.				
g.				

39. Briefly describe each sibling and your relationship with him/her:

a.
b.
c.
d.
e.
f.
g.

Answer the following questions based on your knowledge of your childhood:

- | | | | |
|-----|--|------------------------------|-----------------------------|
| 40. | Was your mother's pregnancy and/or delivery of you difficult? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 41. | Did you have any unusual childhood illnesses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 42. | Were you ever hospitalized as a child? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 43. | Did you have any serious or recurrent accidents as a child? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 44. | Any history of childhood or adult seizure disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 45. | Any delays in learning how to walk, talk, or be toilet trained? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 46. | Did you ever have problems with bedwetting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 47. | Any problems with your speech or language development? Stuttering? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 48. | Any serious difficulties with concentration or with sitting still? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 49. | Were you involved in fighting as a child? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 50. | Were you involved in truancy (skipping school)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 51. | Did you experience the death of a sibling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

52. Briefly describe your childhood, including what it was like growing up in your family, going to school, and other important events and activities.

53. What was the best part about your childhood?

54. What was the worst part about your childhood?

55. What ways were you disciplined by your **father** as a child? (Mark all that apply).

Severe physical punishment, including beatings, hitting, etc.

Mild physical punishment, such as spanking.

Severe verbal punishment, such as yelling and screaming.

Mild verbal punishment.

Emotional withdrawal or isolation (for example, your father would emotionally withdraw from you, not talk to you, avoid you, etc.).

Public or private humiliation.

Gentle, but firm discipline (describe): _____

Little or no discipline was provided by my father.

Other (describe): _____

56. What ways were you disciplined by your **mother** as a child? (Mark all that apply.)

- Severe physical punishment, including beatings, hitting, etc.
- Mild physical punishment, such as spanking.
- Severe verbal punishment, such as yelling and screaming.
- Mild verbal punishment.
- Emotional withdrawal or isolation (for example, your mother would emotionally withdraw from you, not talk to you, avoid you, etc.).
- Public or private humiliation.
- Gentle, but firm discipline (describe): _____
- Little or no discipline was provided by my mother.
- Other (describe): _____

57. How did you feel about the discipline you received?

58. Was there any physical, sexual, or emotional abuse in your family? Any parental neglect? If YES, was it of mild, moderate, or severe intensity? Who was or may have been involved? Please describe separately:

- Physical abuse: _____
- Sexual abuse: _____
- Emotional abuse: _____
- Parental neglect: _____

59. To what extent do you have any significant gaps in your memories of childhood and adolescence?

60. To what extent have childhood fears or phobias caused you serious distress or interfered with your family life or school performance? Use the list that follows as a guide. Indicate one or more categories that may have applied to you.

- Fear of the dark
- Fear of bugs, spiders, snakes
- Fear of being left alone
- Fear of going to school
- Fear of other animals
- Other fears (please specify): _____

Description of fear(s) or phobia(s) and the effect on you:

61. How often did you lie to your teachers or parents? (Select category.)

- Rarely, if ever
- Occasionally
- Regularly
- Often
- Almost every day

<p>62. How often did you steal or shoplift things as a child or adolescent? (Select category.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rarely, if ever <input type="checkbox"/> Occasionally <input type="checkbox"/> Regularly <input type="checkbox"/> Often <input type="checkbox"/> Almost every day
<p>63. As a child or adolescent, did you have a best friend? Please describe:</p>
<p>64. Describe your peer group as a pre-adolescent. Mark all categories that apply.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Large <input type="checkbox"/> Small <input type="checkbox"/> Popular <input type="checkbox"/> Unpopular <input type="checkbox"/> Based on sports <input type="checkbox"/> Based on academics or other school experiences <input type="checkbox"/> Mainly girls <input type="checkbox"/> Mainly boys <input type="checkbox"/> Mixed, boys and girls
<p>65. Describe your peer group as an adolescent. Mark all categories that apply.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Large <input type="checkbox"/> Small <input type="checkbox"/> Popular <input type="checkbox"/> Unpopular <input type="checkbox"/> Based on sports <input type="checkbox"/> Based on academics or other school experiences <input type="checkbox"/> Mainly girls <input type="checkbox"/> Mainly boys <input type="checkbox"/> Mixed, boys and girls
<p>66. How old were you when you first reached puberty?</p>
<p>67. How old were you when you had your first romantic relationship?</p>
<p>68. To what extent is your present sexual life satisfactory to you? If it is not, please describe:</p>
<p>69. To what extent did you discuss sexual topics with your parents? Please describe:</p>

70. As a child or teenager, were you ever raped, molested, or subjected to what you or others considered inappropriate sexual behavior by someone? Yes No
 If "YES," please describe:

71. As a child or teenager, were you ever involved, sexually or romantically, with someone more than four years older than yourself? Yes No
 If "YES," please explain:

72. Has your sexual behavior ever caused you or anyone else any problems? Yes No
 If "YES," please explain:

73. I consider the following to have been true of me while I was a child. (Mark all that apply.)

<input type="checkbox"/> Parent at home very little, absent	<input type="checkbox"/> Parents at home almost always, present
<input type="checkbox"/> Adult-like, overly serious	<input type="checkbox"/> Playful, child-like, immature
<input type="checkbox"/> Powerless, victim, target, helpless	<input type="checkbox"/> Powerful, capable, independent
<input type="checkbox"/> Vain, arrogant, pretentious	<input type="checkbox"/> Humble, polite, simple
<input type="checkbox"/> Sad, blue, pessimistic	<input type="checkbox"/> Optimistic, cheerful, hopeful
<input type="checkbox"/> Poorly read, uninformed	<input type="checkbox"/> Well-read, informed
<input type="checkbox"/> Uneducated, undereducated	<input type="checkbox"/> Well educated, overeducated
<input type="checkbox"/> Thoughtless, shallow, superficial	<input type="checkbox"/> Thorough, substantial, thoughtful
<input type="checkbox"/> Impulsive, inconsistent, distractible	<input type="checkbox"/> Ordered, consistent, planned
<input type="checkbox"/> Chaotic, unstable, unreliable	<input type="checkbox"/> Reliable, stable, orderly
<input type="checkbox"/> Closed, controlling	<input type="checkbox"/> Trusting, open
<input type="checkbox"/> Cold, distant, unavailable	<input type="checkbox"/> Available, warm, close
<input type="checkbox"/> Intrusive, disrespectful	<input type="checkbox"/> Respectful, considerate
<input type="checkbox"/> Critical, conditional	<input type="checkbox"/> Supportive, accepting
<input type="checkbox"/> Dishonest	<input type="checkbox"/> Especially honest
<input type="checkbox"/> Bully, angry, violent	<input type="checkbox"/> Victim, scapegoat, target
<input type="checkbox"/> Tense, worried, unsure	<input type="checkbox"/> Sure, secure, stable, calm
<input type="checkbox"/> Passive, meek, timid, frightened	<input type="checkbox"/> Confident, assertive, bold
<input type="checkbox"/> Self-centered, self-indulgent	<input type="checkbox"/> Generous, empathic
<input type="checkbox"/> In ill health or injured	<input type="checkbox"/> Always in good health
<input type="checkbox"/> Mis-used alcohol	<input type="checkbox"/> Drank none or very little
<input type="checkbox"/> Mis-used street drugs	<input type="checkbox"/> Used none or very little
<input type="checkbox"/> Mis-used medications	<input type="checkbox"/> Used medications only as prescribed

Legal problems: _____

Employment problems: _____

Financial problems: _____

Sexual problems: _____

Other problems: _____

Relationship/Marital History

74. List all marriages, cohabitations, divorces, and/or separations you have had. Include if you have been widowed.
 Note: In the table below, "Spouse/Partner Age," refers to age at the beginning of the relationship.

Nature of Relationship	Date (From/To)	Reason for Separation/Divorce	Spouse/Partner Age	Spouse/Partner Occupation

75. Do you have any children? Yes No
 If "YES," complete the following chart; if "NO," skip to the next item.

Child's Name	Relationship	Age	Residence	If not with you, indicate City and State of child's residence.
	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step child <input type="checkbox"/> Foster child <input type="checkbox"/> Other (explain):		<input type="checkbox"/> With me <input type="checkbox"/> With former spouse <input type="checkbox"/> Other (explain):	
	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step child <input type="checkbox"/> Foster child <input type="checkbox"/> Other (explain):		<input type="checkbox"/> With me <input type="checkbox"/> With former spouse <input type="checkbox"/> Other (explain):	
	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step child <input type="checkbox"/> Foster child <input type="checkbox"/> Other (explain):		<input type="checkbox"/> With me <input type="checkbox"/> With former spouse <input type="checkbox"/> Other (explain):	
	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step child <input type="checkbox"/> Foster child <input type="checkbox"/> Other (explain):		<input type="checkbox"/> With me <input type="checkbox"/> With former spouse <input type="checkbox"/> Other (explain):	
	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step child <input type="checkbox"/> Foster child <input type="checkbox"/> Other (explain):		<input type="checkbox"/> With me <input type="checkbox"/> With former spouse <input type="checkbox"/> Other (explain):	

76. If you are presently involved with a spouse/partner, please describe two major problem areas you experience.

77. Do you have any birth children that were given up for adoption? Yes No

78. Have your parental rights ever been terminated or restricted? Yes No

79. Has any child of yours ever been placed in foster care? Yes No

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

Educational History

80. Please list **all** of the schools you have attended:

School Attended	Location	Dates of Attendance	Graduation Status	Degree(s) Received

81. Please describe your grades and academic performance in grade school, junior high, and high school.
 Grade School:

 Junior High School:

 High School:

82. Did any of the following happen to you? Mark all that apply. If "YES," please explain.
 Expelled from school
 Suspended from school
 Held back for a year in school
 Advanced a grade
 Placed in a special class
 Explanation of any of the above:

83. Do you have any learning disabilities? If "YES," please describe:

84. Indicate with a checkmark any special academic interests:
 Math and science
 Fine arts
 History
 Literature
 Philosophy
 Other (please specify): _____

85. Indicate the single academic area in which you are *most* competent. Make only one selection.
 Math and science
 Fine arts
 History
 Literature
 Philosophy
 Other (please specify): _____

86. Indicate the single academic area in which you are *least* competent. Mark only one selection.

- Math and science
- Fine arts
- History
- Literature
- Philosophy
- Other (please specify): _____

Occupational History

87. List all jobs which you have held, both paid and unpaid/voluntary, since you were 18 years old. Begin with your most recent position.

Position Title or Nature of Work	Location	Dates (From/To)	Reason for Leaving	Supervisor's Name

88. Have you ever been fired from a position? Yes No
89. Have you ever prematurely/abruptly resigned from a position? Yes No
90. Have you ever been asked to resign from a position? Yes No
91. If you have ever supervised others as part of a position, have there been any difficulties? Yes No
92. Has tension or anger in a domestic relationship ever flowed into your workplace, affecting your relationships with supervisors or coworkers? Yes No

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

93.	Describe the worst problem you have experienced at a position and how you handled it.
94.	Describe, as specifically as possible, the characteristics of an ideal "supervisor" that would optimally motivate you?
95.	Describe at least two or three features of a satisfying ministry or work project you have concentrated on recently or in the past (e.g., working with others who are responsive to my ideas, seeing a particular project completed that I began).
96.	Describe the most important feature of a very satisfying work day for yourself.
97.	What personality traits or behaviors in others do you find difficult to accept or like?
98.	What personality traits in yourself do you think may sometimes be a problem for others?
99.	List the important ingredients of a successful career in the ministry.

Medical History

100. Have you ever had any major medical problems? Yes No
101. Have you ever been hospitalized for medical problems? Yes No
102. Have you ever had problems with your heart, lungs, liver, or kidneys? Yes No
103. Do you have any allergies to any medications? Yes No
104. Have you ever had any surgery? Yes No
105. Have you ever had a problem with your weight? Yes No
106. Have you ever had major concerns about your weight, body size or shape? Yes No

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response. (If you need more space, please use the pages provided at the end of this questionnaire.)

107. Do you currently take prescription medication for any medical problems? Yes No
If "YES," please list each medication, dose, duration of use, and reason for use.

Medication	Dosage & Route	Medical Condition	Date Started	Date D/C
a.				
b.				
c.				

108. Do you currently take any non-prescription medication of any kind? Yes No
(e.g., laxatives, vitamins, food supplements, herbal preparations, over-the-counter sleeping pills)
If "YES," please list each medication, duration of use, and reason for use.

Medication	Dosage & Route	Medical Condition	Date Started	Date D/C
a.				
b.				
c.				

109.	Have you ever received alternative medical care (e.g., homeopathy, faith healing, etc.)? If "YES," please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
110.	Have you ever used any prescription medications in the past for more than two weeks? If "YES," please list each medication, dose, duration of use, and reason for use.	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Medication</th> <th style="width: 25%;">Dosage & Route</th> <th style="width: 30%;">Medical Condition</th> <th style="width: 15%;">Date Started</th> <th style="width: 15%;">Date D/C</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Medication	Dosage & Route	Medical Condition	Date Started	Date D/C	a.					b.					c.					
Medication	Dosage & Route	Medical Condition	Date Started	Date D/C																		
a.																						
b.																						
c.																						
111.	Have you ever had a major head injury? If "YES," please describe each such occurrence, date of the injury, and whether you lost consciousness (and for how long you lost consciousness).	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
112.	When was the last time you saw a physician? _____ For what reason?																					
113.	How many times have you seen a physician in the last five years? How many times have you seen a physician in the last year?																					
114.	Have you ever disregarded a physician's or other health provider's advice? If "YES," please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
115.	Do you smoke cigarettes or use other tobacco products? If "YES,"	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
	<input type="radio"/> how much do you smoke/use daily? _____ <input type="radio"/> how long have you been smoking or using other tobacco products? _____ Describe any attempts to quit.																					

Psychiatric History

116. Have you ever sought professional help or a self-help program for emotional problems? Yes No
 If "YES," complete the chart below.

Type of Care	Dates of Care or Duration	Reason for Visit/ Admission	Nature of Treatment (psychotherapy, medication)	Your Response to Treatment
Outpatient				
Partial/Day Hospital				
Inpatient/ Residential				

117. Have you ever been or are you currently treated with medication for an emotional problem? Yes No
 If "YES," complete the chart below.

Medication	Dosage	Condition Being Treated	Date Started	Date Stopped
a.				
b.				
c.				

118. Have you ever seriously thought about taking your own life? Yes No

119. Have you ever attempted to kill yourself? Yes No

120. Have emotional problems ever significantly interfered with your work and/or academic performance? Yes No

121. Have you ever been a party to sexual abuse, child abuse, physical abuse, or sexual exploitation? Yes No

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

122. Have you ever engaged in, or been told that you have a diagnosis of any of the following? Yes No

If "YES," please mark that item and **describe** the circumstances.

- Exhibitionism (exposure of one's genitals to a stranger)
- Fetishism (use of non-living objects for sexual gratification)
- Frotteurism (rubbing a non-consenting person)
- Pedophilia (adult's sexual activity with a prepubescent child or adolescent)
- Sexual masochism (obtaining sexual gratification from being humiliated, beaten, bound, or otherwise made to suffer)
- Sexual sadism (inflicting psychological or physical suffering on someone else to obtain sexual satisfaction)
- Voyeurism (observing unsuspecting people, usually strangers, who are naked, disrobing, or engaging in sexual activity)

Circumstances:

123. To your knowledge, has any blood relative (grandparents, parents, aunts, uncles, nephews, cousins, siblings, or children) ever

- | | |
|--|--|
| <input type="checkbox"/> received or sought out professional help for any emotional problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> been treated with medication for any emotional problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> received or sought out professional help for a drug or alcohol problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> had a history of untreated emotional and/or drug or alcohol problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

124. In the past year, on average: How many alcoholic drinks did you have each week? _____ How many drinks have you had in the past year? _____	
125. Have you ever used/consumed alcohol on a daily basis? How much did you use daily? _____ Over what period of time? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
126. Have you ever drank so much that you could not remember what happened by the next morning? If "YES," describe the circumstances.	<input type="checkbox"/> Yes <input type="checkbox"/> No
127. Have you ever tried to cut down on the amount you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
128. Have you ever become annoyed with others when they discuss your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
129. Have others ever raised concerns about your drinking patterns or behavior while drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
130. Do you ever feel guilty about your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
131. Have you ever taken a drink in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
132. Has your drinking ever caused you problems at work, school, or at home with your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
133. Have you ever been charged with or convicted for driving while intoxicated or driving under the influence of alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
134. Is it ever hard for you to stop drinking after only one drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
135. Did you ever take a drink before going out to a function where you know there will be no alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.	

136. Place a checkmark beside any of the following drugs that you now use or have ever used:

- | | |
|---|---|
| <input type="checkbox"/> Marijuana or hashish | <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Heroin or other narcotics | <input type="checkbox"/> Crack |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> LSD |
| <input type="checkbox"/> Barbiturates or downers | <input type="checkbox"/> Diet pills* |
| <input type="checkbox"/> Tranquilizers of any kind* | <input type="checkbox"/> Sleeping pills* |
| <input type="checkbox"/> Hallucinogens (for example, mescaline, psilocybin) | <input type="checkbox"/> PCP (angel dust) |
| | <input type="checkbox"/> Laxatives and/or diuretics |
- Other drug (specify): _____
- Other drug (specify): _____

* If you used these drugs while under the care of a physician and used them according to the physician's prescription/order, you do not need to complete the next section.

137. If you marked a substance above, list when you used the drug, over what period of time, and average daily and weekly amount of the drug used. Also state your longest period of abstinence from the drug.

Name of Drug	Date Usage Began	Date Stopped	Average Daily/ Weekly Amount Used	Longest Period Of Abstinence

138. Have you ever been treated for or sought professional help for a drug, alcohol or eating problem? Yes No

139. Have you ever attended Alcoholics Anonymous, Narcotics Anonymous or any of the other 12-step programs? Yes No

If you checked "YES" to either of the two questions above, complete the chart below:

Type of Care	Dates of Care or Duration	Reason for Visit/ Admission	Nature of Treatment (psychotherapy, medication)	Your Response to Treatment
Outpatient/ Self-help				
Partial/Day Hospital				
Inpatient/ Residential				

Legal History

140. Have you ever been charged with a crime of any kind? Yes No
141. Have you ever been convicted of any crime? Yes No
142. Have you ever been placed on probation? Yes No
143. Have you ever been charged with traffic violations, including vehicular homicide or driving while intoxicated? Yes No
144. Has your drivers license ever been suspended or revoked? Yes No
145. Have you ever been incarcerated? Yes No
146. If you have been divorced, have you ever fallen behind on court-ordered child support or alimony payments? Yes No
147. Have you ever initiated a lawsuit? Yes No
148. Have you ever been a defendant in a lawsuit? Yes No

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

Financial History

149. Select the category which most closely approximates your family's annual income bracket during your childhood and adolescence:

- | | |
|--|--|
| <input type="checkbox"/> Under \$15,000 | <input type="checkbox"/> \$60,000 – \$74,999 |
| <input type="checkbox"/> \$15,000 – \$24,999 | <input type="checkbox"/> \$75,000 – \$99,999 |
| <input type="checkbox"/> \$25,000 – \$39,999 | <input type="checkbox"/> \$100,000 – \$150,000 |
| <input type="checkbox"/> \$40,000 – \$49,999 | <input type="checkbox"/> Over \$150,000 per year |
| <input type="checkbox"/> \$50,000 – \$59,999 | |

150. Select the category which most closely approximates the highest annual income you have ever received:

- | | |
|--|--|
| <input type="checkbox"/> Under \$15,000 | <input type="checkbox"/> \$60,000 – \$74,999 |
| <input type="checkbox"/> \$15,000 – \$24,999 | <input type="checkbox"/> \$75,000 – \$99,999 |
| <input type="checkbox"/> \$25,000 – \$39,999 | <input type="checkbox"/> \$100,000 – \$150,000 |
| <input type="checkbox"/> \$40,000 – \$49,999 | <input type="checkbox"/> Over \$150,000 per year |
| <input type="checkbox"/> \$50,000 – \$59,999 | |

What year did you reach this income level:

151. Has your family ever experienced any significant financial changes? Yes No
152. Are you currently or have you ever experienced serious financial difficulties? Yes No
153. Have you ever declared bankruptcy? Yes No
154. Do you have any ongoing problems with personal/family financial management? Yes No
(e.g. credit card debt, foreclosures, problems with debt collectors, compulsive gambling)

If you checked "YES" to any of the questions above, please provide a description of the circumstances or a more detailed response.

