

LIFE SCRIPT/AUTOBIOGRAPHY*

The following is a guideline for you to follow in developing your life script. The purpose of completing this is to get a clear picture of your life history, events, and people, which have had an impact on your development. Please answer to the best of your ability/comfort.

If you have any questions about the Life Script – it's significance or how it is u in this Healing Care process, please feel free to reach out to Kerry and Jan McIntyre for a conversation. They may be reached at kerry.janmc@gmail.com.

All information provided in this Life Script will be kept confidential by the leaders and will be shredded at end of the program.

Name: _____ Age: ____ Gender Identification: _____

Address: _____

City: _____ Prov: _____ Post Code: _____

Home Phone: _____ Cell: _____

Occupation: _____ Marital Status: _____

Spouse's Name: _____ Age: _____

How long have you been married? _____ Spouse's Occupation: _____

Children's First Names & Ages: _____

FAMILY

How many people were in your childhood family? _____

With whom did you live? _____

Who were you closest to and why? _____

What did you like to do with your family? _____

How much time did you spend with them everyday? _____

Describe your parents briefly. _____

What did your mother say when she complimented you? _____

Criticized you? _____

What did your father say when he complimented you? _____

Criticized you? _____

What significant memories do you have regarding school? _____

Did anyone in your family drink too much? _____

How did they act toward you if they had been drinking? _____

What dysfunctions impeded healthy relationships within your childhood family? _____

Describe your parents' religious experience. _____

Were your parents married or divorced? _____

Was your father the head of the home or did your mother fill this role? _____

How did your father treat your mother? _____

How did your mother treat your father? _____

Was there ever an adulterous affair with your parents or grandparents? _____

Was there ever any incestuous relationship? _____

Were or are there addictive problems in your family history? _____

Was there any history or evidence of mental illness? _____

How many people are in your current household? _____

Describe your relationship to your spouse, your children, and your parents. _____

Describe the level of communication between household members. _____

List four things you would like to change about how your family relates to one another.

1. _____
2. _____
3. _____
4. _____

IMPORTANT EVENTS

What is your earliest memory? _____

What is your happiest memory? _____

What is your saddest memory? _____

Describe any major losses in your life (deaths, moves, relationships, suicides, job changes, etc.).

What other events influenced your life? Describe them and state how they influenced you.

SELF

In my free time, I like to: _____

The last good book I read was: _____

My major life accomplishments are: _____

I consider my greatest failure to be: _____

My most irrational act: _____

If I could do it all over again I would: _____

My biggest goal for the future is: _____

Describe how you see yourself right now (socially, emotionally, intellectually and spiritually).

Socially: _____

Emotionally: _____

Intellectually: _____

Spiritually: _____

Do you like yourself right now? _____

If you could change anything about yourself, what would it be? _____

List five strengths you have.

1) _____

2) _____

3) _____

4) _____

5) _____

List five weaknesses/growth areas you have.

1) _____

2) _____

3) _____

4) _____

5) _____

How do you work on areas needing growth? _____

In what specific areas do you struggle? (Be concise). How long have you struggled in these areas?

Are there any other problems which seem to grow out of these struggles? _____

Have you struggled with suicidal thoughts? How did you cope and what did you do?

Do you have or have you had in the past a mental health condition or diagnosis (depression, anxiety, bi-polar, borderline, etc.)? _ Please list: _____

If you are taking medications for a mental health condition, please list: _____

Do you consider yourself : (please circle one)

emotionally stable somewhat stable less than stable somewhat unstable unstable

Are you experiencing bouts of anger or mood swings presently? If so, please explain:

FRIENDS

How many friends do you have? ____ How many do you consider your closest friends?

Who is your best friend and why? _____

How much time everyday do you spend with your friends, including phone time? _____

How do your friends/peers influence your life? _____

Have your social contacts changed recently? ____ Why? _____

Do you have any enemies and if so why? _____

WORK

Describe your work and how it impacts you personally (include past work experiences as well).

Are you fulfilled in what you do? _____

What are your hopes, plans, dreams concerning your vocation? _____

To what degree is your identity linked to your vocation? _____

Explain how your finances affect you. _____

DIET/EXERCISE

Do you generally eat a healthy, well-balanced diet? _____

Describe any imbalance. _____

How satisfied are you with your body (choose only one)?

Extremely Dissatisfied

Fairly Dissatisfied

Somewhat Dissatisfied

Neutral Somewhat

Satisfied Fairly

Satisfied

Extremely Satisfied

Do you, or others close to you, think you are overly concerned with your weight? _____

If yes, describe. _____

Do you, or others close to you, think you are overly concerned with exercising? _____

If yes, describe. _____

DRUG/ALCOHOL USE:

Indicate which of the following substances you currently use or have used in the past:

Drug	Past	Frequency of use	Present	Frequency of use
Alcohol				

Marijuana/THC				
LSD				
Benzodiazepine				
Amphetamines				
Crack				
Opiates				
Barbituates				
PCP				
Methamphetamines				
Heroin				

Have you ever experienced negative consequences caused by your drinking or drug use? ___

If yes, describe. _____

Have you ever received treatment for your own drug or alcohol use? _____

If yes, please indicate type of treatment, dates and degree of success. _____

Do you ever experience blackouts, periods of time which you are unable to account for? ___

If yes, describe. _____

SPIRITUAL INVENTORY:

Do you have regular devotions in the Bible? _____ When and to what extent?

Do you find prayer difficult? _____ Explain, including when & how this affects you.

How would you describe your spiritual life at this point in your life?

Are you presently enjoying fellowship with other believers, and if so, where and when?

PREVIOUS & CURRENT TREATMENT

Are you currently seeing a counselor or therapist? _____ If yes, please describe frequency and length of time, plus a brief synopsis of the nature of your sessions/treatment.

AUTHORIZATION/CONSENT:

I give my permission for the information contained in this Life Script to be used by the leaders of Healing Care.

(signature)

(date)