

NAME _____

PERSONAL CHECKLIST (Please check off all items that apply to you.)

My Present Feelings

- | | | | |
|-------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Fear of _____ | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Oversensitivity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Frustration | <input type="checkbox"/> Hurt | <input type="checkbox"/> Resentment |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Guilt | <input type="checkbox"/> Inferiority | <input type="checkbox"/> Self-pity |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Grief | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Vulnerability |
| <input type="checkbox"/> Distrust | <input type="checkbox"/> Hatred | <input type="checkbox"/> Irritability | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Envy | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Jealousy | <input type="checkbox"/> Worthlessness |
| | | | <input type="checkbox"/> Other _____ |

How I handle my emotions:

- I freely express them all. To whom? _____
- I express some only. Which ones? _____ Why? _____
- I tend to suppress them all. Why? _____
- I am not in touch with my feelings.
- I disregard my emotions because I don't trust them.
- I feel guilty about having the following emotions: _____

My Past Experience

- | | | |
|---|--|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Fired from job | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Abandonment | <input type="checkbox"/> Illegitimate child | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Alcoholic parents | <input type="checkbox"/> Injury | <input type="checkbox"/> Rejection |
| <input type="checkbox"/> Bankruptcy | <input type="checkbox"/> Illness | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Betrayal | <input type="checkbox"/> Imprisonment | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Born out of wedlock | <input type="checkbox"/> Loss of _____ | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Child sexual abuse | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Other crises or losses |
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Neglect by parents | _____ |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Overprotective parent | |

My Present Problems

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Addiction/s (sex, alcohol, gambling, drugs, pornography) | <input type="checkbox"/> Failure pattern | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Premarital sex |
| <input type="checkbox"/> Affair | <input type="checkbox"/> Flash-backs | <input type="checkbox"/> Lying | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Anorexia/bulimia | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Memory gaps | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> Frigidity | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Compulsive behaviour | <input type="checkbox"/> Gambling | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Critical spirit | <input type="checkbox"/> Hallucination | <input type="checkbox"/> Non-assertiveness | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Headaches | <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Hostile behaviour | <input type="checkbox"/> Overeating | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Impatience | <input type="checkbox"/> Perfectionism | |
| | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Pornography | |
| | <input type="checkbox"/> Insomnia | | |

My Mental / Spiritual Orientation

I daily spend about _____ hours listening to music; _____ hours watching TV; _____ hours reading

These are my favourite types of

Music: _____

TV programs: _____

Reading material: _____

To me, God is _____

I think God feels _____ about me.

My religious faith consists of _____

My Family of Origin

The following words describe my mother: _____

I have feelings of _____ for my mother.

The following words describe my father: _____

I have feelings of _____ for my father.

My parents' marriage was _____

I felt closest in my family to _____

The emotional atmosphere in my home was _____

As a child I felt _____

Being a teenager for me was _____

My Marriage (or other serious relationship)

My marriage (or other relationship) is _____

The following things bother me about my partner: _____

I am responsible for causing the following problems in our relationship: _____

As a parent I feel _____

Any other comments that may be pertinent:
