



LIFECCHANGE RESOURCES

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Family Life Mosaic

Questionnaire

Past to Present



Please type or use a dark pen when completing this form.

Counsellor's Name: _____

First appointment date: ____/____/____

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

For Office Use Only

Date Received: _____

Notes:

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 ministering to you, you will facilitate your counselling by saving time and expense. Your prayer minister will keep this record strictly confidential, and the information is not available to anyone without your written permission.

(*A child or client who cannot read and write may be asked the questions by an adult and the person's answers written for them. **Information unknown to the child may be entered by an adult.**)

TODAY'S DATE: ____/____/____

By what name would you like to be called? _____

NAME _____ PHONE (home): (____) ____/____
 FIRST MIDDLE LAST PHONE (work): (____) ____/____
 CELL phone: (____) ____/____

STREET ADDRESS _____ Apt: _____ May we call you at work? Yes No
 FAX: (____) ____/____

MAILING ADDRESS _____ E-MAIL: _____

CITY _____ STATE/PROV. _____

COUNTRY _____ ZIP/POSTAL CODE _____ - _____

AGE: ____ BIRTHDATE: ____/____/____

Emergency contact person (other than spouse) _____ PHONE (home): (____) ____/____
 RELATIONSHIP _____ PHONE (work): (____) ____/____

STREET ADDRESS _____ Apt: _____

Are you or were you in military service Yes No If yes, which branch of the military? _____

Religion/Denomination: _____ Place of Worship: _____

Worship Attendance (check one): Regular Occasional Not at All

I learned about or was referred to LIFECHANGE RESOURCES., by _____

I requested my prayer minister by name: Yes No

How strongly do you want help for your problem? (check one) Very much Moderately Could do without

I have talked about my problem with:

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

PLEASE BE BRIEF AND CONFINE YOUR ANSWERS ONLY TO THE SPACE PROVIDED.

NEED FOR COUNSELING: **State in your own words the nature of your concern.**

If your problem is cyclical or has a pattern to it, state approximately how often it occurs and how long it lasts.

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

Have you ever been diagnosed with a mental illness or disorder? If so, please explain.

Has it ever been **suggested** you be tested for: a) Bi-Polar b) Borderline Personality Disorder

c) Dissociation/DID d) Depression e) Schizophrenia f) Other: _____

Comments

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

BEGINNINGS

Place a check mark in front of all 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 Caesarean Section
- I was a wanted baby. 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 (difficult labor/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 events in your early childhood were significant to you?

List the number of “times you moved” in your first 18 years of life.

Age:	From:	To:	Reason:

FAMILY DATA

Please be prepared to complete a genogram as one of your assignments during your time at LIFECHANGE. A genogram is a 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 from oldest to youngest, **including yourself**. Please list in birth order, including any miscarriages, or abortions you know about.

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

Describe your relationship to your brothers and sisters in childhood.

Describe the relationship to your brothers and sisters presently.

Who played together and why?

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?

How would you describe the atmosphere of your childhood home?

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

List any fearful or distressing experiences not previously mentioned:

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?

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

Do you make friends easily? Do you keep them?

EDUCATIONAL HISTORY

School/College/University	Major/Degree	Date Received:

EMPLOYMENT HISTORY (List from most recent to earliest)

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

How much money do you and your spouse earn? Under \$20,000 Over \$20,000 Over \$75,000

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? How was it discussed or instructed?

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

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

Did you ever have any anxieties, 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 inappropriately in a sexual way? If yes, please explain:

Menstrual History

Age at 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 and/or concerns you have about sex, sexual experiences and/or sexual identity, past/present or future?

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 biological parent/s and attach that page to the back of this life history

FATHER'S Name: _____	MOTHER'S Name: _____
Current age: _____	Current age: _____
Occupation before retiring: _____	
If deceased, what was the cause of death and their age? _____	
What was your age? _____	
His Personality	Her Personality
His Values	Her Values
Kind of home environment he provided	Kind of home environment she provided

Describe you Father's relationship with Mother?

Describe your Mother's relationship with Father?

Who was in charge? Who was the real head of the house?

Describe his relationship with the children?

Describe her relationship with the children?

How did he show love?

How did she show love?

What was his ambition for the children?

What was her ambition for the children?

Describe your ability to confide in him

Describe your ability to confide in her

(Continued) FATHER

MOTHER

Form of punishment he used

Form of punishment she used

As a child, what I liked about him

As a child, what I liked about her

As a child, what I disliked about him

As a child, what I disliked about her

Who was Dad's favorite child? Why?

Who was Mom's favorite child? Why?

Which child was most like him? Why?

Which child was most like her? Why?

Which child was most different from him? Why?

Which child was most different from her? Why?

Describe any problems with addictions and/or immorality

Describe any problems with addictions and/or immorality

What is your Father's ethnic heritage?

What is your Mother's ethnic heritage?

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			
1 st Marriage							
2 nd Marriage							
3 rd Marriage							
4 th Marriage							

PLEASE BE BRIEF AND CONFINE YOUR ANSWERS ONLY TO THE SPACE PROVIDED.

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 children |
| _____ 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 things you would like to see your spouse do more often (particular things that mean something to you)

Give three specific examples of 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. State if any of these children are from previous marriages, or adopted. **Also, in order of birth include any miscarriages or abortions.**

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

PREVIOUS MARRIAGES

What I liked about him/her:

What I disliked about him/her:

What my previous spouse liked about me:

What my previous spouse disliked about me:

What ended the relationship?

FAMILY LIFE MOSAIC QUESTIONNAIRE

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

FAMILY LIFE MOSAIC QUESTIONNAIRE

<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>	kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	liver problems
<input type="checkbox"/>	<input type="checkbox"/>	feel tense	<input type="checkbox"/>	<input type="checkbox"/>	stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	feel panic	<input type="checkbox"/>	<input type="checkbox"/>	paralysis	<input type="checkbox"/>	<input type="checkbox"/>	fear going to hell
<input type="checkbox"/>	<input type="checkbox"/>	cold sores	<input type="checkbox"/>	<input type="checkbox"/>	nightmares	<input type="checkbox"/>	<input type="checkbox"/>	sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	sees God as distant	<input type="checkbox"/>	<input type="checkbox"/>	poor work performance
<input type="checkbox"/>	<input type="checkbox"/>	difficult to pray	<input type="checkbox"/>	<input type="checkbox"/>	High energy	<input type="checkbox"/>	<input type="checkbox"/>	frustration	<input type="checkbox"/>	<input type="checkbox"/>	bad home conditions	<input type="checkbox"/>	<input type="checkbox"/>	sees God as harsh
<input type="checkbox"/>	<input type="checkbox"/>	low energy	<input type="checkbox"/>	<input type="checkbox"/>	easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>	fear success	<input type="checkbox"/>	<input type="checkbox"/>	martyr	<input type="checkbox"/>	<input type="checkbox"/>	difficult to read Bible
<input type="checkbox"/>	<input type="checkbox"/>	fear God	<input type="checkbox"/>	<input type="checkbox"/>	feel inferior	<input type="checkbox"/>	<input type="checkbox"/>	difficulty deciding	<input type="checkbox"/>	<input type="checkbox"/>	spiritual abuse	<input type="checkbox"/>	<input type="checkbox"/>	unable to hold boundaries
<input type="checkbox"/>	<input type="checkbox"/>	verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	fear travel	<input type="checkbox"/>	<input type="checkbox"/>	bad reaction to anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	bitter	<input type="checkbox"/>	<input type="checkbox"/>	bullied as child	<input type="checkbox"/>	<input type="checkbox"/>	lack common sense	<input type="checkbox"/>	<input type="checkbox"/>	hard to tell right from wrong
<input type="checkbox"/>	<input type="checkbox"/>	feel invisible	<input type="checkbox"/>	<input type="checkbox"/>	physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>	difficulty deciding what to wear
<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	brain injury	<input type="checkbox"/>	<input type="checkbox"/>	see life as good	<input type="checkbox"/>	<input type="checkbox"/>	can't express feelings	<input type="checkbox"/>	<input type="checkbox"/>	fear losing mind
<input type="checkbox"/>	<input type="checkbox"/>	infertility	<input type="checkbox"/>	<input type="checkbox"/>	learning disability	<input type="checkbox"/>	<input type="checkbox"/>	see life as bad	<input type="checkbox"/>	<input type="checkbox"/>	flooded by feelings	<input type="checkbox"/>	<input type="checkbox"/>	fear will hurt others
<input type="checkbox"/>	<input type="checkbox"/>	mental illness	<input type="checkbox"/>	<input type="checkbox"/>	dread weekends	<input type="checkbox"/>	<input type="checkbox"/>	not listened to	<input type="checkbox"/>	<input type="checkbox"/>	unhappy childhood	<input type="checkbox"/>	<input type="checkbox"/>	fear terminal illness
<input type="checkbox"/>	<input type="checkbox"/>	dread vacations	<input type="checkbox"/>	<input type="checkbox"/>	dread holidays	<input type="checkbox"/>	<input type="checkbox"/>	happy childhood	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	see moving shadows

FAMILY LIFE MOSAIC QUESTIONNAIRE
SPIRITUAL EXPERIENCES

Please place a check mark beside each item in which you or your family members have participated.

Keys: **S** = self **F** = family (immediate) **G** = Generational (Father, mother, grandparents)

S	F	G	
			Animism
			Ancestral Worship
			Astral-projection
			Astrology
			Automatic writing
			Bahai
			Black/white magic
			Blood pacts
			Bloody Mary
			Buddhism
			Christian Science
			Clairvoyance
			Dowsing (water-witching)
			Drugs

S	F	G	
			New Age
			Ouija board
			Palm reading
			Pendulum & rod
			Reading tea leaves, etc.
			Rosicrucian
			Roy Masters
			Santeria
			Satanism
			Science of Creative Intelligence
			Science of the Mind
			Scientology
			Séance
			Shintoism

FAMILY LIFE MOSAIC QUESTIONNAIRE

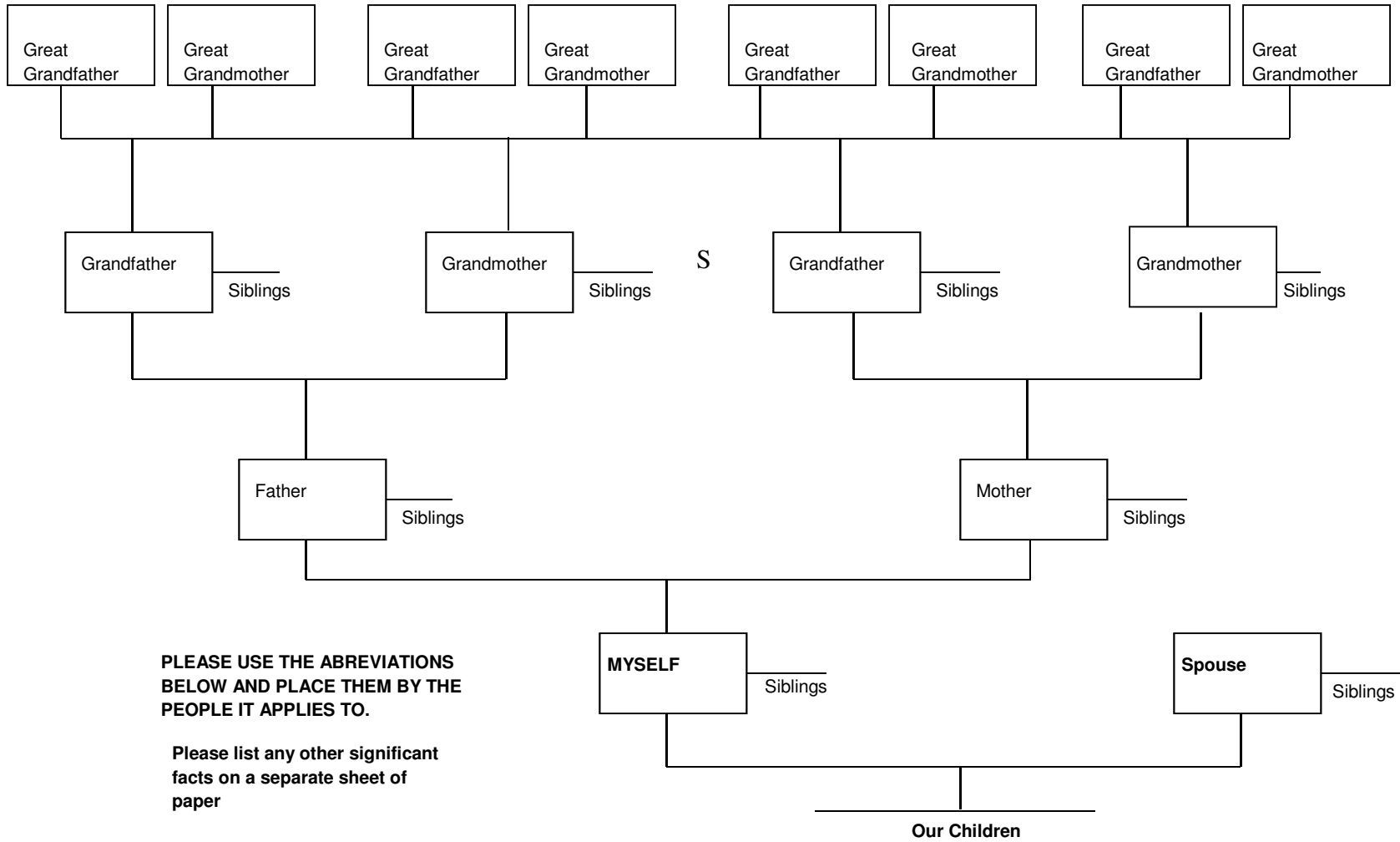
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eckankar
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EST
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father Divine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fetishism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fortune telling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ghosts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Good Luck Charms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hare Krishna
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hinduism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypnosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incubi/succubae(sex spirits)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Islam
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jehovah's Witness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Magic charming
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Masons (Freemasonry.....
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eastern Star, Demolay,
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job's Daughters, Shriners)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Materialization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mind Control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mormonism

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Silva Mind Control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spells
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swedenborgianism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tarot cards
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telekinesis (i.e., table lifting)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telepathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The "Local Church" (the cult)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Way International
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Theosophical Society
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trance speaking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transcendental Meditation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unification Church
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unitarianism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Voodoo
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wicca
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witchcraft
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yoga
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

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

it were . . .

House School of Healing Ministry Inc. (2013). *Life history questionnaire*. Retrieved from <http://www.elijahhouse.org>



NOTABLE PROBLEMS

AA	Substance Abuse (name substance)	P	Prejudices
AB	Addictive Behavior	PA	Physical Abuse
B	Barrenness	PD	Premature Death
D	Deceased	PI	Physical/Chronic Illness
DV	Divorced	SA	Sexual Abuse
F/A	Fear / Anxiety	S/O	Satanic/Occult Involvement
FL	Financial Loss / Poverty	SU	Suicide
FM	Free Masonry	T	Thievery
H/T	Homosexual / Transsexual etc	UG	Unresolved Grief
I	Incest	V/AD	Violent/Accidental death/murdered
ID	Infant Death/Miscarriage/stillborn/aborted		
IP	Infidelity /Sexual Promiscuity		
M	Committed Murder		
MI	Mental Illness		
O	Other (name)		

Adapted from, P. (2012). *From Generation to generation: A manual for healing* (4th ed.) (p. 199). Generational Healing Ministries: Westport, MA.