Spiritual DNA Questionnaire

Part I

Name:____ Date:__________________________

DOB:__________________________ Age:___________ Established _____

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

What Spiritual DNA concerns do you have with your fiancée? ____

Marital Status: *(circle)* S M D W E Occupation: *(if retired, previous occupation)* ________________________________

Have you completed Advanced Directives or do you have a Living Will? *(circle)* No Yes Which? ___________________

What is the current state of you future in-laws? *(circle) Good* Poor Indifferent? ______________________

Tell us a little about your home environment: *(e.g., live alone, with family, single parent, house, apt., etc.)*

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which?_______________________________________

Full Disclosure – Pending Nuptials

List Traits that you are concerned with regarding your Fiancée and within your Fiancée's family background (Bad Debt, Undisclosed Children *(circle)* No Yes Please explain why you have these concerns to your mate? Why?________

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have*

Have you ever had or been diagnosed to have: *(check box by all that apply)?*

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/Lung Disease		Kidney Stone(s)		German Measles		High Cholesterol	
Seizures/Epilepsy		Pleurisy		Diabetes or Prediabetes		Rheumatic Fever		Prostate Enlargement	
Heart Attack or Angina		Jaundice or Liver Disease				Chicken Pox			
				Thyroid Disease		Syphilis			

Spiritual Trait you are concerned with:
Please list traits that you want deliverance from? *Recurrent?*

Current?	Trait	Generation?	Reason	Mother/Father

Sins of Father History	Age	Health *(list significant illness)*	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Have your Parents ever had? (*check if Yes and indicate relationship)*

__Alzheimer's ___
____Heart Attack before age 55____
Alcoholism ___

__Tuberculosis ___
____Bleeding Disease____________
Mental Disorder ___

__Diabetes ___
____Stroke_____________________
Verbal Abuse ___

__High Blood Pressure ___
____Seizures___________________
Asthma ___

__Heart Disease ___
____Depression/Suicide__________
Cancer ___

__Unforgiveness ___
____Excessive Debt __________
Control ___

__Divorce ___
____ Untimely Death__________
Pride ___

__Abandonment ___
____No Ambition_____________
Physical Abuse ___

__Poverty or Lack ___
____Bipolar (diagnosed)_______
Gambling ___

__Barrenness ___
____Addictions_______________
Fornication ___

Please continue to the next page

Physical Questionnaire - Level 2

Name ____

DOB:_________________________Age:___________

PLEASE NOTE: This section of the medical history contains questions that may be of a very personal and highly confidential aspect of your health. While a medical professional will treat all information within your medical chart as confidential records, this section of the questionnaire is primarily for premarital training and research for pending nuptials. THIS IS NOT A REAL MEDICAL FORM. For informational purposes only.

The following sets of questions are to help us identify problem areas that may be difficult to discuss. Circle **yes** or **n**o to each question and discuss any ***yes*** answers with your physician or nurse practitioner.

Do you drink alcohol? (circle) *No Yes* If Yes, check the following:

_____Rarely social (less than once/wk)
_____Beer, 12 oz./day
_____Wine, 1 glass/day

_____Hard liquor, 1-3 oz./day
_____Beer, 2 bot./day
_____Wine, 2 glasses/day

_____Hard liquor, over 3 oz./day
_____Beer, 3 bot. or more /day
_____Wine, 3 or more glasses/day

Do you use regularly, or have you used in the past marijuana, cocaine, heroin, speed, crack or other inhalants? *No Yes*

Have you felt you need alcohol or other drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other inhalants)? *No Yes*

Have you felt that you use too much alcohol or other drugs? *No Yes*

Have you tried to cut down or quit drinking alcohol or your use of drugs? *No Yes*

Do you feel you have a drinking or a drug problem at this time? *No Yes*

Personal Safety

Do you feel safe at home? *No Yes*

We all have arguments - when you and your partner or a family member argue, have you ever been physically hurt or threatened? *No Yes*

Do you feel your partner, or a family member controls (or tries to control) your behavior too much? *No Yes*

Does he or she threaten you? *No Yes*

Has your partner (or a family member) ever hit, pushed, shoved, punched or kicked you? *No Yes*

Have you ever felt forced to engage in unwanted sexual acts or sexual contact with your partner or other family member? *No Yes*

Mental Health

Have you been diagnosed to have depression? *No Yes*

Have you been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric condition? *No Yes*

HIV Exposure

Have you ever been diagnosed to be HIV Positive? *No Yes*

Do you have any concerns about possible exposure? Have you informed your Fiancée? *No Yes*

Premarital Couple signature__________________________

Date:____

Name of your Fiancée______________________________________

Date:____