

Ministry in Prayer

CONFIDENTIAL QUESTIONNAIRE

Contact Information:

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Birth Date: _____

Email Address: _____ Gender: Male Female

Have you experienced deliverance ministry before? Yes No

To answer the questions below please circle all that apply and fill in the blanks as honestly as possible.

Marital Status: Single Married Separated Divorced Widowed

How many times have you been married? _____ Spouse's name: _____

Describe your current marital status _____

Are you currently the victim in an abusive relationship? Yes No

Spiritual Status: Are you a "born again" Christian? Yes No Not Sure

When were you born again? _____ Do you have assurance of your salvation? Yes No Not Sure

Have you been baptized? Yes No Do you have your prayer language? Yes No

Do you attend church? _____ Where? _____

Are you experiencing any difficulty with the following? Bible Study Prayer Worship Spiritual Gifts

Describe concerns: _____

Are you ready to be set free and change any habits that are related to your circumstances? Yes No

Are you ready to forgive those who hurt you and repent of your sins? Yes No

Personal Status:

Have you been previously diagnosed by a professional counselor? Yes No

If yes, what was the diagnosis? _____

List any current prescription medication and health concerns: _____

Do you use either prescription or non-prescription drugs to help you sleep? Yes No

Have you ever had a nervous breakdown? Yes No If yes, when? _____

Do you suffer from panic or anxiety attacks? Yes No Frequency? _____

Have you ever been raped as an adult? Yes No If yes, when? _____

What is your greatest fear in relationships? _____

Are you easily angered? Yes No Do you feel rejected often? Yes No

Are you easily offended? Yes No Is it difficult for you to forgive? Yes No

Do you have problems making decisions and staying with your decision? Yes No

Have you ever heard voices from the inside, especially under stress? Yes No

Do you have any difficulty remembering the first ten years of your life? Yes No

Describe any large memory gaps: _____

Does your handwriting change or go from printing to cursive? Yes No

Describe any emotional traumas that placed you in survival mode: _____

Have you ever been injured in an automobile or other vehicle accident? Yes No

Family of Origin:

Where were you raised? _____ How many siblings did you have? _____

Where were you in birth order? _____ Describe any issues with siblings _____

Describe your relationship with your father. _____

Describe your relationship with your mother. _____

Circle the items that apply to your childhood. Underline the items that are a current concern.

- | | | | |
|----------------|--------------------|------------------|------------------------|
| Night Terrors | Bed Wetting | Sleep Walking | Learning Difficulties |
| Adoption | Religious Rigidity | Parental Divorce | Removed from Home |
| Alcoholism | Drug Addiction | Eating Disorders | Abandonment/Neglect |
| Physical Abuse | Sexual Abuse | Spiritual Abuse | Verbal/Emotional Abuse |

To your knowledge, did you experience molestation, incest or inappropriate touch as a child? Yes No

Who hurt you? _____

Have you ever been subjected to occult ritual abuse? Yes No

Did your parents lean on you for support? Yes No Describe: _____

Did your parents wish you were of the opposite sex? Yes No

On a scale from 1-10 was your childhood home cold and unloving or warm and very loving?

Cold/Unloving 1 2 3 4 5 6 7 8 9 10 Warm/Loving

Are there any family members you don't feel loved by? _____

Have you ever used street drugs? Yes No Please List: _____

Do you struggle with cravings or addictions? Yes No Please describe: _____

Circle the items below that are a concern for you personally.

- Daydreaming Inferiority Unworthiness Insecurity Lustful Thoughts Shame Worry Fear
- Doubt Unbelief Anxiety Stress Swearing Lying Guilt Anger Hatred Distrust
- Compulsions Dizziness Headaches Obsessive Thoughts Bitterness Depression Frustration
- Fear of Losing Mind Impatience Fear of Death Vengeance Uncontrollable Rage Violence
- Murderous Thoughts Death Wish Self Mutilation Suicidal Thoughts Perfectionism Gambling
- Pornography Alcoholism Shopping Anorexia Bulimia Workaholic Homosexuality
- Over-Eating Tobacco Marijuana Money

Have you ever had an abortion? Yes No If so, how many? _____ When? _____

Have you viewed X-Rated movies or pornography? Yes No Involved in prostitution? Yes No

Family Heritage:

Were your ancestors of European royal descent? Yes No Were Gypsies in the family? Yes No

Do you have American Indian ancestors? Yes No Please describe your family lineage: _____

Does your name have any particular significance as to family tradition or cultural/national heritage? Yes No

Please describe: _____

To your knowledge, have your parents, grandparents or great-grandparents ever been involved in any cult, occult, New Age or non-Christian religious practices? _____

What religion did your parents practice? _____ Grandparents? _____

Please place a V next to the items listed below that apply to any member of your family including siblings, aunts and uncles, cousins etc.

- ___ Mormonism ___ Catholicism ___ Jesuit Order
- ___ Christian Science ___ Unity Church ___ Santeria
- ___ New Age ___ Buddhism ___ Hinduism
- ___ Islam/Muslim ___ Scientology ___ Freemasonry/Shriners

Demolay Jobs Daughters Eastern Star
 Satanism Baha'i Rosicrucian
 Jehovah Witness Hare Krishna Theosophy
 Reincarnation Ku Klux Klan Mafia

Is there any family history of suicide? Yes No If yes, whom? _____

Circle any of the following in the family line:

Schizophrenia Bi-Polar Disorder Depression MPD Personal Spiritual Inventory

What spiritual experiences have you had that would be considered out of the ordinary? _____

Have you ever felt you have had sex with a demon (incubus or succubus)? Yes No

Have you ever had choking sensations or pains which seem to move and for which there is no medical cause?

Yes No

Explain: _____

Have you participated in any occult activities including childhood games? Circle all that apply.

Ojai Board Psychic Reading New Age Fair Crystal Ball Reading Palm Reading Channeling
 Séance Astrology/Horoscopes Levitation Astral Travel Yoga Transcendental Meditation
 Chanting Voodoo Clairvoyance Divination Telepathy Telekinesis Numerology
 Automatic Writing Witchcraft Wicca Paganism Spell Casting Hypnosis Self Hypnosis
 Mind Control Curses Blood Pacts Vows Covenants Table Tipping Kabala Water
 Witching Harry Potter Magic Dungeons & Dragons Pendulum Runes Amulets/Charms
 Tea Leaf Readings ESP Edgar Cayce Metaphysics Pokémon Auras Jean Dixon
 Martial Arts Tarot Cards Shamanism Indian Spiritism Light as a Feather

Have you been inside a Buddhist or Mormon temple or any type of Lodge for a secret society? Yes No

Have you had treatment from alternative medicine providers? Yes No

If yes, please describe: _____

Have you served in the military overseas? Yes No Where? _____ When? _____

Are the experiences you had in the military causing nightmares or problems for you today? Yes No

Specifically which issue would you like to begin addressing at your first meeting? _____

In order of priority, what other issues do you wish to address?

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

Please list any questions or concerns you would like to address before ministry begins.