THE CENTER FOR DEPTH HEALING

GOALS WORKSHEET

(Please write legibly and fax this page back to the doctor prior to your first appointment.)

Please make a list of specific challenges that you face in life, on the psychological, emotional, or physical level, which if removed, would enable you to more easily reach your personal goals. This list may encompass problems you feel are old and recurrent, or ones which are relatively new.

Please identify the primary challenges you face in life related to either one or more of the sample goals listed, or to an *unlisted* personal goal which you yourself may describe in the last space provided. (Please feel free to use the back of this page if space is insufficient.)

SAMPLE GOAL #1: **Achieving loving relationships with family/friends/others**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

***SAMPLE GOAL #2*: Obtaining happiness and peace/clarity of mind**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

***SAMPLE GOAL #3*: Having a healthy body and freedom from physical pain**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

***SAMPLE GOAL #4*: Living in the now--letting go of the past and releasing fear, worries, and anxiety over the future**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

***SAMPLE GOAL #5*: Overcoming addictive/compulsive/or negative behaviors**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

***OTHER GOAL*: _____**
I would like to be free of the following problems which pose a block to realizing this goal:
_____
_____
_____

(Please Cont. On Page 2)

Goals Worksheet (Continued) - Page 2

Background Personal Information:

Marital Status: _____

History Of Separation Or Divorce: Yes ☐ No ☐

How Many Children Do You Have? _____

How Many Siblings Do You Have? _____

Do You Live By Yourself? [Y] [N] If Not, With Whom? _____

Are You Currently Receiving Care From a Doctor, Mental Health Professional, Therapist, Healer, Bodyworker? Yes ☐ No ☐
If Yes, Please List _____
_____

Do You Have Any Physical or Mental Health Conditions Which You Haven't Listed On Page 1 Of The Goals Worksheet? Yes ☐ No ☐
If Yes, Please List _____
_____

Do You Have A History Of Any Significant Illnesses: Physical, Psychological, Or Substance Addiction Issues InYour Past? Yes ☐ No ☐
If Yes, Please List _____
_____

Are You Currently Taking Any Medication? Yes ☐ No ☐
If Yes, Please List _____
_____

How Is Your Diet? Are You Currently Taking Any Herbal or Nutritional Supplements? Yes ☐ No ☐
Please Describe: _____
_____
_____

Do You Use Any Forms Of Spiritual/Emotional/Psychological Means, Tools, Or Practices To Enhance Your Wellbeing? Yes ☐ No ☐
If Yes, Please List _____
_____

What Is Your Average Weekly Intake Of...
Alcohol? _____Pain Killers? _____ Cigarettes? _____
Recreational Drugs? _____ Caffeine? _____

Print Name _____ Date _____