

**Supplemental Personal Data Inventory**

**Greater Ohio District Board of Ministerial Development (DBMD)**

Thank you for taking the time to complete this form. Before completing this form, you must complete the DBMD #1 form and have it ready to submit with this form to the district office.

We ask that you complete all the following questions as honestly and openly as possible. This form will only be reviewed by our DMBD counseling team, the DBMD chairperson, and your cohort leader. *This form will not be made public, will not be made available to the district, will not be viewable by the District Superintendent, will not be available to a local church, and will not be passed to another district without your consent*. The purpose of this inventory is to help you be prepared, as best as possible, for a lifelong healthy ministry and to help us, as the DBMD, to assess your ability to do so.

Because of confidentiality issues DO NOT send this form to the district office. This form MUST be EMAILED to **Jeremy Hayworth** (our DBMD counselor) at: [jhayworth1@yahoo.com](mailto:jhayworth1@yahoo.com)

*(Glitch in the form: when clicking on a check box you must click on text to begin typing again.)*

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| **Date this form was completed:** | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | | | | | | | |
| **Social Security #** | | |  | | |  | | | | | |  | | | | | | |
| **Have you completed the DMBD #1 form?** | | | | | | | | | | | | Choose an item | | | | | | |
| If no, complete DBMD #1 first and have it ready to submit along with this inventory. | | | | | | | | | | | | | | | | | | |
| **What is your race/ethnicity?** Choose an item | | | | | | | | | | | | | | | | | | |
|  | Multiracial (please specify): | | | | | | | |  | | | | | | | | | |
|  | International (please specify): | | | | | | | |  | | | | | | | | | |
| **How much do you identify with your ethnic heritage?** Choose an item | | | | | | | | | | | | | | | | | | |
| **Does your family speak a language other than English at home?** Choose an item | | | | | | | | | | | | | | | | | | |
| **Were you and both your biological parents born in the U.S.?** Choose an item | | | | | | | | | | | | | | | | | | |
| If no, who was foreign-born: | | | | | | | |  | | | | | | | | | | |
| From what country: | | | |  | | | | | | | | | | | | | | |
| What was the approximate age of immigration to the U.S.: | | | | | | | | | | | | | | |  | | | |
| **Family of Origin**  Who were your primary caregivers in childhood? Please mark all that apply. | | | | | | | | | | | | | | | | | | |
| **Father** | | | **Mother** | | | | | | | **Stepfather** | | | | **Stepmother** | | | **Grandfather** | |
| **Grandmother** | | | **Uncle** | | | | | | | **Aunt** | | | | **Other** | | |  | |
|  | | | | | | | | | | | **Caregiver #1** | | | | | **Caregiver #2** | | |
| First and Last Name of *Primary* Caregiver: | | | | | | | | | | |  | | | | |  | | |
| Living or deceased: | | | | | | | | | | |  | | | | |  | | |
| Occupation (past and current): | | | | | | | | | | |  | | | | |  | | |
| Cause of death (if deceased): | | | | | | | | | | |  | | | | |  | | |
| How would you rate this caregiver's approach to rearing you (please select): | | | | | | | | | | | Choose an item | | | | | Choose an item | | |
| **For the next 3 questions rate the quality of your relationship with each caregiver** | | | | | | | | | | | | | | | | | | |
| When you were a child: | | | | | | | | | | | Choose an item | | | | | Choose an item | | |
| When you were a teenager: | | | | | | | | | | | Choose an item | | | | | Choose an item | | |
| Now…as an adult: | | | | | | | | | | | Choose an item | | | | | Choose an item | | |
|  | | | | | | | | | | | | | | | | | | |
| **Siblings** - list all siblings (biological, step, half, other) and rate your quality of relationship  (1-very negative 2-somewhat negative 3-neutral or not applicable 4-somewhat positive 5-positive) | | | | | | | | | | | | | | | | | | |
| First and Last Name | | | | | Age | | Gender | | | | | | #of years you lived together | | | | | Rate Your Relationship |
|  | | | | |  | |  | | | | | |  | | | | | choose |
|  | | | | |  | |  | | | | | |  | | | | | choose |
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|  | | | | |  | |  | | | | | |  | | | | | choose |

**Please check any past, present, or impending problems/issues in your family** **of origin**

deaths  physical/sexual abuse  divorce

financial crisis/unemployment  frequent relocations  legal problems

debilitating injuries/disabilities  attempted/completed suicide  alcohol/drug abuse

eating disorders  serious/chronic illness  mental illness

marital affairs/infidelity or other sexual issues  other Click here to enter text.

**Please specify family member(s) and which problem(s)/issue(s) they face:**

|  |
| --- |
|  |

**In general, how happy or adjusted were you growing up?**

poor  below average  average  above average  completely

**How much is your family of origin a source of emotional support for you?**

none  little  somewhat  substantial  always

**How much conflict in values do you currently experience with your parents?**

none  little  sometimes  substantial  always

|  |  |  |
| --- | --- | --- |
| **Who in your family of origin do you currently feel closest to?** | |  |
| **Most distant from?** |  | |
| **In most conflict with?** |  | |

**If Married:**

|  |  |
| --- | --- |
| **Relationship with Spouse** Rate your quality of relationship 1-very negative 2-somewhat negative 3-neutral 4-somewhat positive 5-positive | |
| How does my spouse feels about my call? | choose |
| Rate the quality of your relationship with your spouse. | choose |
| How do you feel about the quantity of conflict in your relationship? | choose |
| How do you feel about your ability to resolve conflict with your spouse? | choose |
| How do you feel about your ability to minister together? | choose |
| How do you feel about your connectedness? | choose |
| What would your spouse say the quality of your relationship is today? | choose |

**Please check any past, present, or impending problems/issues with you or those living with you.**

deaths  physical/sexual abuse  divorce

financial crisis/unemployment  frequent relocations  legal problems

debilitating injuries/disabilities  attempted/completed suicide  alcohol/drug abuse

eating disorders  serious/chronic illness  mental illness

marital affairs/infidelity or other sexual issues  other Click here to enter text.

**Please specify family member(s) and which problem(s)/issue(s) they face:**

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Who lives at home with you?** Rate your quality of relationship 1-very negative 2-somewhat negative 3-neutral or not applicable 4-somewhat positive 5-positive | | | | |
| First and Last Name | Age | Gender | Relationship to you? | Rate Relationship |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |
|  |  |  |  | choose |

**In general, how happy or adjusted is the atmosphere in your home?**

poor  below average  average  above average  excellent

**How much is your immediate family a source of emotional support for you?**

none  little  somewhat  substantial  always

**How much conflict do you currently experience at home?**

none  little  sometimes  substantial  always

|  |  |
| --- | --- |
| **Who in your home do you currently feel closest to?** |  |
| Most distant from? |  |
| In most conflict with? |  |

**Physical Health**

**How would you describe your physical health:**

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Are you having any problems with your sleep habits?** | | | | | | yes  no | | |
| **If yes, check where applicable** | | sleeping too little | | | | | | sleeping too much |
| poor quality sleep | | | | | | disturbing dreams |
| other: | |  | | | | |
| **How many times per week do you exercise:** | | |  | | | | | |
| **For how long:** | | |  | | | | | |
| **Are you or have you ever had any difficulty with appetite or eating habits**? | | | | | | | yes  no | |
| **If yes, check where applicable**:  eating less  eating more  binge eating  restricting calories  significant weight change (in past two months) | | | | | | | | |
| **Do you have any physical concerns/chronic illnesses/long-term medical conditions?** | | | | | yes  no | | | |
| **Are you under a doctor’s care for these?** | | | | | yes  no | | | |
| **What is your prognosis:** |  | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Recreation and Leisure Activities** | | |
| **Rate Degree of Enjoyment 1-very little 2-a little 3-a fair amount 4-a lot 5-a great deal** | | |
| **Name of Activity** | **Degree of Enjoyment** | **Rate Frequency** |
|  | choose | choose |
|  | choose | choose |
|  | choose | choose |
|  | choose | choose |
|  | choose | choose |
|  | choose | choose |

**Relational Health**

**How would you describe your relational health?**

|  |
| --- |
|  |

**In the past, how would you rate the quality of your peer relationships?**

poor  below average  average  above average  excellent

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Closest Friends** Rate your quality of relationship 1-very negative 2-somewhat negative 3-neutral 4-somewhat positive 5-positive | | | | | | |
| First Name | Age | | Gender | Length of friendship | How do you maintain contact? | Rate relationship |
|  | |  |  |  |  | choose |
|  | |  |  |  |  | choose |
|  | |  |  |  |  | choose |
|  | |  |  |  |  | choose |
|  | |  |  |  |  | choose |
|  | |  |  |  |  | choose |

**Mental Health**

**How would you describe your mental/emotional health?**

|  |
| --- |
|  |

**Are you currently receiving psychiatric services, professional counseling or therapy?**

yes  no

**Have you ever had previous counseling or psychotherapy?**  yes  no

If yes, please specify reason for the counseling and what you feel you learned from it:

|  |
| --- |
|  |

**Have you ever been hospitalized for psychiatric reasons:**  yes  no

If yes, please explain:

|  |
| --- |
|  |

**Have you ever been prescribed medication for psychiatric reasons:**  yes  no

If yes, please elaborate:

|  |
| --- |
|  |

**Have you had suicidal thoughts recently:**  yes  no

How often? daily  weekly  monthly  rarely

**Have you had them in the past:**  yes  no

How often? daily  weekly  monthly  rarely

**Have you ever intentionally inflicted harm upon yourself?**  yes  no

How often? daily  weekly  monthly  rarely

**Nature of harm:**

|  |
| --- |
|  |

**Have you ever intentionally hurt someone else?**  yes  no

**Nature of harm:**

|  |
| --- |
|  |

**Have you ever experienced any form of traumatic experience**  yes  no

**If yes, please explain when and the nature of the experience:**

|  |
| --- |
|  |

**Have you personally experienced abuse:**  yes  no  unsure

Was the abuse:

verbal  emotional  physical  sexual

**How does the future look to you:**

poor  fair  neutral  good  excellent

**How would you rate your current ability to cope:**

poor  fair  neutral  good  excellent

**Sexual Health**

**How would you describe your sexual health?**

|  |
| --- |
|  |

**Have you ever been involved in a sexual relationship with someone?**

*(outside of / or before marriage with your current spouse)*   yes  no

***If yes, please explain:***

|  |
| --- |
|  |

**Have you ever experienced sexual assault, unwanted sex, or uncomfortable touching?**

frequently  a few times  once  never  unsure

**Were you introduced to *anything* sexual either too early or in an inappropriate way?**

frequently  a few times  once  never  unsure

**Have you ever felt guilty about your sexual behavior?**  yes  no

**Has your sexual behavior ever created problems for you or your family?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***No problems*** | | | | ***Some problems*** | | | | ***Multiple problems*** | | | |
|  |  |  |  | |  |  |  | |  |  |  |
| 1 | 2 | 3 | 4 | | 5 | 6 | 7 | | 8 | 9 | 10 |

**Have you made efforts to quit a type of sexual activity and failed?**  yes  no

**Have you ever been afraid that others will find out about your sexual activity?**  yes  no

**Do you ever feel controlled by your sexual desire?**  yes  no

**The internet has created sexual problems for me?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***No problems*** | | | | ***Some problems*** | | | | ***Multiple problems*** | | | |
|  |  |  |  | |  |  |  | |  |  |  |
| 1 | 2 | 3 | 4 | | 5 | 6 | 7 | | 8 | 9 | 10 |

**Has sex (or fantasies) been a way for you to escape your problems, reward yourself or deal with uncomfortable emotions?**  yes  no

**Have you struggled with sexual desire for the same sex?**  yes  no

**Have you ever asked anyone for help to stop unwanted sexual behavior?**  yes  no

**My family viewed sexuality as:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Bad, don’t talk about it** | | | | | **God-given, discussed openly** | | | | |
|  |  |  |  |  |  |  |  |  |  |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**I feel like my family’s view of sexuality was healthy?**  yes  no  unsure

**I am currently involved in an accountability relationship that includes questions about my sexual behavior**.  yes  no

**Referring to my accountability relationship, I am:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Less than honest** | | | | | **Completely honest** | | | | |
|  |  |  |  |  |  |  |  |  |  |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**There are sexual concerns I would welcome help in working through, but I have been scared to tell anyone because I don’t know what will happen as a result.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I don’t have concerns** | | | | | **Please help** | | | | |
|  |  |  |  |  |  |  |  |  |  |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**AGAIN**

Because of confidentiality issues DO NOT send this form to the district office. This form MUST be EMAILED to **Jeremey Hayworth** (our DBMD counselor) at: [jhayworth1@yahoo.com](mailto:jhayworth1@yahoo.com)