

**General Questions and Exercises—Map Key #1**

With a new, integral appreciation of health you can now begin to take inventory of the state of your own health. Take time answering the questions that follow and in performing the exercises. Your goal is to take a snapshot of where you are currently located on the map of your health. Using this information will help you to chart a course to arrive at a place of better health. There are no right or wrong answers to these questions. Be honest.

ON A SCALE OF 1--10 HOW DO YOU RATE YOUR HEALTH?

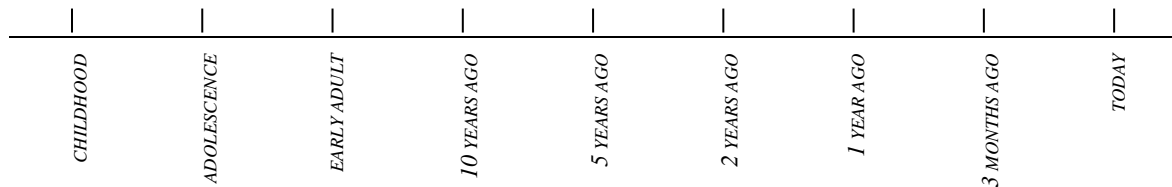
*Sickly 1* \_\_\_\_\_ *10 Optimum health*

WHAT NEEDS TO CHANGE TO MOVE FROM YOUR CURRENT TO A HIGHER SCORE?

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

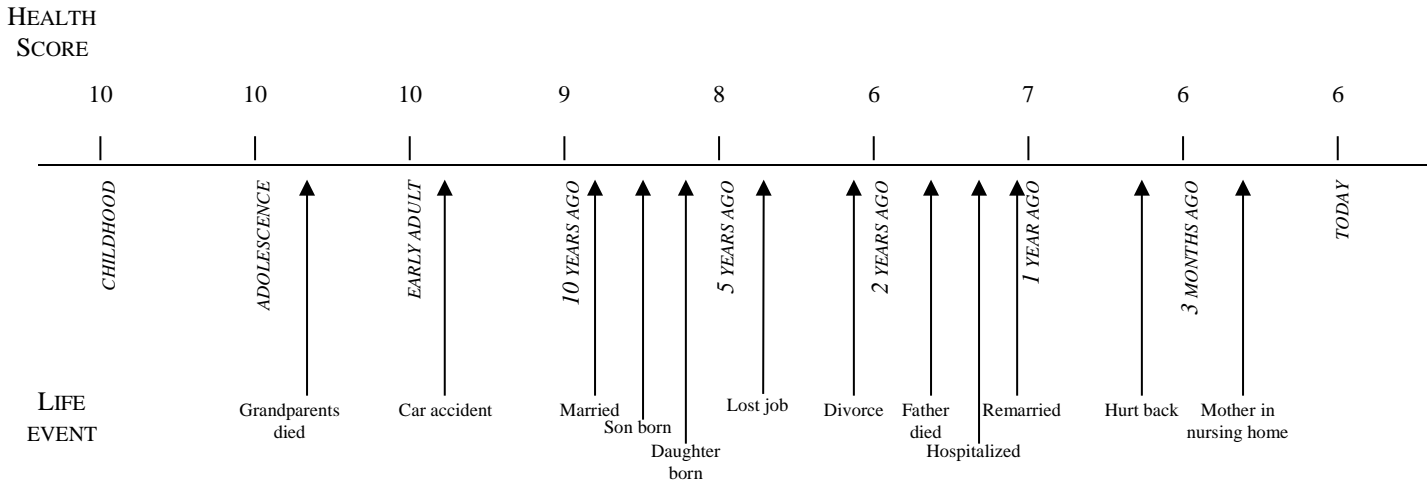
WHEN DID YOU LAST FEEL WELL? \_\_\_\_\_

FILL IN YOUR HEALTH SCORE (1-10) ON THE TIMELINE BELOW

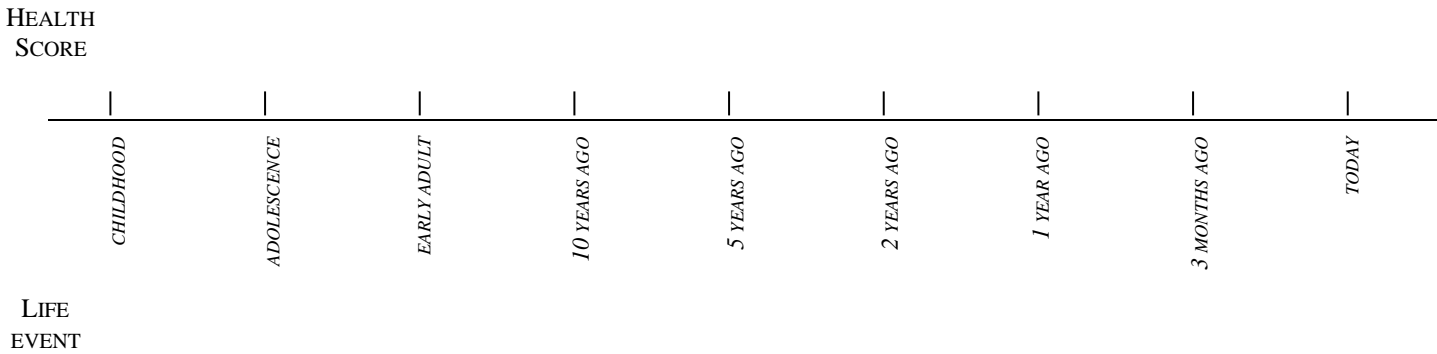


Now fill in some important life events on the same time line. These events might include things such as childhood illness, trauma, death of a loved one, breakup of a significant relationship, marriage, becoming a parent, etc.

I've given you an example below:



Now complete yours:



CAN YOU SEE ANY CORRELATION BETWEEN YOUR OVERALL HEALTH SCORE AS IT RELATES TO SIGNIFICANT EVENTS IN YOUR LIFE?

IF THE ANSWER IS YES, EXPLAIN: \_\_\_\_\_

LIST BELOW YOUR CURRENT DIAGNOSES FOR ANY HEALTH PROBLEMS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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LIST BELOW ANY PRESCRIPTION MEDICATIONS WHICH YOU TAKE REGULARLY:

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WHAT DO YOU EXPECT THESE MEDICATIONS TO ACHIEVE? \_\_\_\_\_

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ARE YOUR EXPECTATIONS FOR WHAT YOUR MEDICATIONS ARE INTENDED TO  
ACHIEVE BEING MET? IF NOT, WHY NOT? \_\_\_\_\_

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LIST BELOW NON-PRESCRIPTION MEDICATIONS, VITAMINS, PILLS, OR SUPPLEMENTS THAT YOU TAKE  
REGULARLY:

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WHAT ADDITIONAL HEALTH PROBLEMS DO YOU HAVE WHICH ARE NOT INCLUDED IN YOUR LIST OF  
DIAGNOSES?

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WHAT DO YOU EXPECT THESE PILLS TO ACHIEVE? \_\_\_\_\_

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ARE YOUR EXPECTATIONS FOR WHAT YOUR PILLS ARE INTENDED TO ACHIEVE  
BEING MET? IF NOT, WHY NOT? \_\_\_\_\_  
\_\_\_\_\_

**Exercise--Map Key #1** (be as complete as possible in filling out the table)

**Review your list of diagnoses and other health problems which you have listed above and complete the table below. The column for “Impact” asks how this affects your daily life (e.g. if you have chronic back pain the impact may be, “Prevents me from playing tennis, being as active as I would like to be”). The column for “Significance” asks why the impact is important to you (e.g. having high blood pressure may have little impact on your day to day life but important significance such as, “Concerned about causing heart attack/stroke” or “ Don’t like to take medication”).**

<b>Health problem/ Diagnosis:</b>	<b>Onset:</b>	<b>Impact:</b>	<b>Significance:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*(as you work through later assessments you may need to attach additional pages to this table)*

**Body Questions and Exercises—Map Key #2**

Let's take a look at your means of transportation. Is it well cared for and maintained? Are there worsening signs of wear and tear or impending breakdown? Are you stranded on the side of the road?

ON A SCALE OF 1--10, RATE YOUR PHYSICAL HEALTH.

*Poor 1* \_\_\_\_\_ *10 Excellent*

DO YOU FEEL THAT YOUR CURRENT WEIGHT IS HEALTHY FOR YOU? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

HOW IS YOUR WEIGHT DIFFERENT THAN FIVE YEARS

AGO? \_\_\_\_\_

DO YOU FEEL THAT YOUR CURRENT DIET IS WELL BALANCED AND HEALTHY? \_\_\_\_\_

DO YOU EAT THREE MEALS A DAY? \_\_\_\_\_

DO YOU SNACK BETWEEN MEALS? \_\_\_\_\_

ARE YOUR MEAL AND SNACK CHOICES HEALTHY? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

LIST YOUR LAST THREE MEALS AND INDICATE WHETHER YOU FEEL THEY ARE OR ARE NOT HEALTHY:

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WHAT BEVERAGES DO YOU TYPICALLY DRINK THROUGHOUT THE DAY? \_\_\_\_\_

HOW MANY SERVINGS OF SODA DO YOU TYPICALLY CONSUME IN A WEEK? \_\_\_\_\_

DO YOU THINK YOUR BEVERAGE CHOICES ARE HEALTHY? \_\_\_\_\_

HOW ACTIVE ARE YOU IN YOUR TYPICAL WORK AND LEISURE ACTIVITIES?

\_\_\_ SEDENTARY \_\_\_ SOME ACTIVITY \_\_\_ ACTIVE \_\_\_ VERY ACTIVE

HOW OFTEN DO YOU ENGAGE IN EXERCISE? \_\_\_\_\_

DOES PAIN LIMIT YOUR PHYSICAL ACTIVITY? \_\_\_\_\_

DO YOU HAVE PROBLEMS WHEN YOU EXERT YOURSELF PHYSICALLY?

IF YES, HOW SO? \_\_\_\_\_

COMPARED TO FIVE YEARS AGO ARE MORE ACTIVE \_\_\_ LESS ACTIVE \_\_\_ ABOUT THE SAME \_\_\_?

IF YOUR ACTIVITY HAS CHANGED, WHY? \_\_\_\_\_

DO YOU THINK YOUR EXERCISE/ACTIVITY PATTERNS ARE HEALTHY? \_\_\_\_\_

HOW MUCH SLEEP DO YOU REQUIRE PER NIGHT TO FEEL WELL RESTED? \_\_\_\_\_

HOW MUCH SLEEP DO YOU TYPICALLY GET PER NIGHT? \_\_\_\_\_

IF YOU REQUIRE MORE SLEEP PER NIGHT THAN YOU TYPICALLY GET, WHAT IS THE REASON FOR THIS? \_\_\_\_\_

DO YOU FREQUENTLY FEEL FATIGUED? \_\_\_\_\_

IF YES, IS THIS MOSTLY A FEELING OF LACK OF ENERGY \_\_\_, SLEEPINESS \_\_\_, OR BOTH \_\_\_?

WHAT ARE THINGS YOU DO WHICH BOOST YOUR ENERGY LEVEL? \_\_\_\_\_

\_\_\_\_\_

WHAT ARE THINGS YOU DO WHICH LOWER YOUR ENERGY LEVEL? \_\_\_\_\_

\_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ DO YOU USE RECREATIONAL DRUGS? \_\_\_\_\_

HOW MANY SERVINGS OF ALCOHOLIC BEVERAGES DO YOU CONSUME IN A TYPICAL WEEK? \_\_\_\_\_

DO YOU RESPECT YOUR PHYSICAL BODY'S NEEDS? \_\_\_\_\_

DO YOU SOMETIMES FEEL THAT YOU ABUSE YOUR PHYSICAL BODY? \_\_\_\_\_

IF YES, WHY? \_\_\_\_\_

IF YOU COULD STEP OUTSIDE YOURSELF AND INTERVIEW YOUR PHYSICAL BODY, WHAT WOULD YOUR BODY WANT TO TELL YOU? \_\_\_\_\_

\_\_\_\_\_

**Map Key #2**

**What habits or activities do you do which you feel help you to be healthier?**

\_\_\_\_\_  
\_\_\_\_\_

**What prevents you from doing these more often?**

\_\_\_\_\_  
\_\_\_\_\_

**What habits or activities do you do which you feel diminish your health?**

\_\_\_\_\_  
\_\_\_\_\_

**Why do you do these?** \_\_\_\_\_

**What prevents you from stopping or doing these less?** \_\_\_\_\_

\_\_\_\_\_

**Overall do you feel physically well balanced? \_\_\_yes \_\_\_no**

**What aspects of your physical body are out of balance?** \_\_\_\_\_

**Update Map Key #1 with any additional health problems you have uncovered**

**Mind Questions and Exercises—Map Key #3**

Now it's time to look at pilot and navigator. Are you moving forward, backward, or around in circles? Are you lost? Where are you headed?

DO YOU EXPERIENCE TROUBLE THINKING CLEARLY? \_\_\_\_\_

IF YES, DESCRIBE HOW/WHY: \_\_\_\_\_  
\_\_\_\_\_

DO YOU EXPERIENCE TROUBLE WITH YOUR MEMORY? \_\_\_\_\_

DO YOU EXPERIENCE TROUBLE FOCUSING OR STAYING ON TASK? \_\_\_\_\_

IF YES, DESCRIBE HOW/WHY: \_\_\_\_\_  
\_\_\_\_\_

DO YOU EXPERIENCE DIFFICULTY MAKING DECISIONS?

IF YES, DESCRIBE HOW/WHY: \_\_\_\_\_

IS IT MORE DIFFICULT FOR YOU TO UNDERSTAND THINGS THAN FOR MOST OTHER PEOPLE? \_\_\_\_\_

HOW INTELLIGENT DO YOU RATE YOURSELF? \_\_\_BELOW AVERAGE\_\_\_ AVERAGE \_\_\_ABOVE  
AVERAGE\_\_\_ FAR ABOVE AVERAGE.

WHAT THINGS DO YOU DO TO STIMULATE YOUR MIND? \_\_\_\_\_  
\_\_\_\_\_

ARE YOU SATISFIED WITH YOUR LEVEL OF MENTAL STIMULATION? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

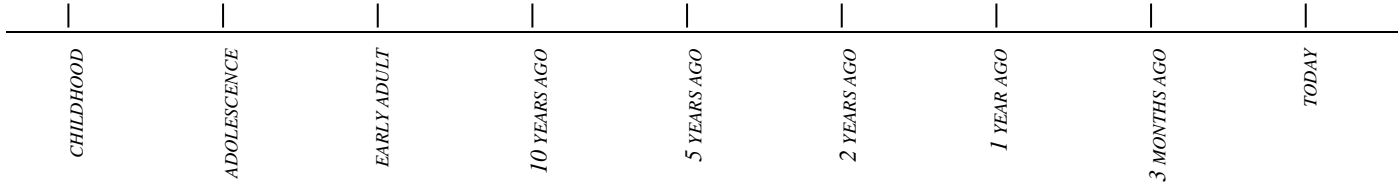


ON A SCALE OF 1--10 RATE YOUR TYPICAL LEVEL OF HAPPINESS:

*Unhappy 1* ————— *10 Very Happy*

ON THE FOLLOWING TIMELINE, INDICATE YOUR HAPPINESS SCORE:

HAPPINESS  
SCORE



WHAT ARE THINGS IN YOUR LIFE WHICH INCREASE YOUR HAPPINESS? INCLUDE WHY THESE THINGS MAKE YOU HAPPIER:

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WHAT ARE THINGS IN YOUR LIFE WHICH DECREASE YOUR HAPPINESS? INCLUDE WHY THESE THINGS MAKE YOU LESS HAPPY:

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WHAT PERCENTAGE OF YOUR TYPICAL DAY DO YOU FEEL UPBEAT? \_\_\_\_\_

LIST PEOPLE, THINGS, CIRCUMSTANCES WHICH GENERATE ANGER THAT IS HIGH INTENSITY, HIGH FREQUENCY, OR PERSISTENT IN DURATION: \_\_\_\_\_

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WHAT “INTERNAL RULES” HAVE BEEN VIOLATED IN THE EXAMPLES ABOVE?

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DOES FEELING ANGRY MAKE YOU FEEL GOOD? \_\_\_\_\_ ARE YOU ADDICTED TO FEELING ANGRY? \_\_\_\_\_

DO YOU THINK BEING ANGRY IS HEALTHY? \_\_\_\_\_

WHAT THINGS DO YOU DO TO REDUCE YOUR ANGER? \_\_\_\_\_

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HAVE ANY OF THESE ANGER REDUCING STRATEGIES BECOME ADDICTIONS? \_\_\_\_\_

**3A. Review your anger list and consider healthy choices you can make to reduce or eliminate anger. This can include deciding not to get angry, ways of minimizing anger, or both. Complete the following table:**

<b>Anger source:</b>	<b>Intensity: (high/low)</b>	<b>Frequency: (often/rare)</b>	<b>Duration: (long/short)</b>	<b>Healthy alternatives</b>

LIST PEOPLE, THINGS, CIRCUMSTANCES WHICH CAUSE FEAR, WORRY, OR ANXIETY THAT IS HIGH INTENSITY, HIGH FREQUENCY, OR PERSISTENT IN DURATION: \_\_\_\_\_

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WHY ARE YOU AFRAID, WORRIED, ANXIOUS ABOUT THESE THINGS? \_\_\_\_\_

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DO YOUR FEARS, WORRIES, OR ANXIETIES MAKE YOU FEEL HEALTHY? \_\_\_\_\_

HAVE FEAR/WORRY/ANXIETY BECOME AN UNHEALTHY RESPONSE PATTERN

FOR YOU? \_\_\_\_\_

WHAT THINGS DO YOU DO TO REDUCE FEAR/WORRY/ANXIETY? \_\_\_\_\_

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HAVE ANY OF THESE BECOME ADDICTIVE? \_\_\_\_\_

DO YOU UNDERSTAND THAT FEELING AFRAID, WORRIED, OR ANXIOUS IS A CHOICE YOU  
MAKE? \_\_\_\_\_

**3B. What healthy choices or strategies are you willing to try to help reduce  
fear/worry/anxiety?** \_\_\_\_\_

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**What other negative emotions such as hatred, guilt, jealousy, shame, etc. are causing you  
imbalance?** \_\_\_\_\_

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**What healthy choices or strategies are you willing to try to help reduce these negative  
feelings?** \_\_\_\_\_

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WHEN YOU CONSIDER THE WORKINGS OF YOUR MIND--THOUGHTS AND EMOTIONS, HOW BALANCED

DO YOU FEEL? \_\_\_\_\_

WHY? \_\_\_\_\_

**3C. What positive emotions would you like to experience more often:**

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**What can you do to experience these positive emotions more often?**

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**What can you do to improve your mental health?**

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**Who can assist you in these efforts?** \_\_\_\_\_

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**Sections 3A, 3B, and 3C above are your Map Key #3**

**Update Map Key #1 with any additional mental health problems you have uncovered**

**Spirit Questions and Exercises—Map Key #4**

Spirit is moving you right now to examine the Integral connections that affect your health. Let's examine your spirit and find out what's moving you.

ON A SCALE OF 1-10 HOW SPIRITUAL ARE YOU?

*Not Spiritual 1* \_\_\_\_\_ *10 Very Spiritual*

WHAT ARE YOUR BELIEFS ABOUT CREATION? \_\_\_\_\_

\_\_\_\_\_

DO YOU CONSIDER YOURSELF A "PERSON OF FAITH"? \_\_\_\_\_

DO YOU BELIEVE IN GOD, A SUPREME BEING, OR SOURCE CONSCIOUSNESS? \_\_\_\_\_

EXPLAIN HOW THIS BELIEF IMPACTS YOUR HEALTH: \_\_\_\_\_

\_\_\_\_\_

HOW DO YOU RELATE TO OR INTERACT WITH GOD/SUPREME BEING/SOURCE

CONSCIOUSNESS? \_\_\_\_\_

DO YOU SOMETIMES FEEL YOU DESERVE TO BE PUNISHED BY GOD OR THAT YOU ARE SOMEHOW BEING PUNISHED BY GOD? \_\_\_\_\_

IF YES, EXPLAIN WHY OR HOW: \_\_\_\_\_

\_\_\_\_\_

DO YOU BELONG TO AN ORGANIZED RELIGION? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

IF YES, DO YOU PARTICIPATE REGULARLY IN YOUR RELIGION? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

DO YOU EXPERIENCE TIMES OF EXPANDED CONSCIOUSNESS? \_\_\_\_\_

IF YES, DESCRIBE THESE: \_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER HAD A MYSTICAL EXPERIENCE? \_\_\_\_\_

IF YES, WHAT HAVE YOU LEARNED FROM THE EXPERIENCE? \_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE A SET OF “CORE VALUES” OR “GUIDING PRINCIPLES“?

IF YES, LIST THEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW WELL ALIGNED ARE YOU WITH THESE CORE VALUES OR GUIDING PRINCIPLES?

\_\_\_NOT VERY\_\_\_ RELATIVELY ALIGNED\_\_\_ HIGHLY ALIGNED

WHAT COULD YOU DO TO IMPROVE YOUR ALIGNMENT? \_\_\_\_\_

\_\_\_\_\_

WHAT DO YOU BELIEVE IS YOUR PURPOSE IN LIFE? \_\_\_\_\_

\_\_\_\_\_

HOW WELL ALIGNED ARE YOU WITH THIS PURPOSE? \_\_\_NOT VERY\_\_\_ RELATIVELY

ALIGNED\_\_\_ HIGHLY ALIGNED

IF YOU ARE NOT WELL ALIGNED, WHY? \_\_\_\_\_

\_\_\_\_\_

DO YOU BELIEVE YOU HAVE A “HIGHER PURPOSE” WHICH IS SOMEHOW RELATED TO GOD? \_\_\_\_\_

IF YES, EXPLAIN THIS RELATIONSHIP: \_\_\_\_\_

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IF YES, HOW WELL ALIGNED ARE YOU WITH THIS PURPOSE? \_\_\_NOT VERY\_\_\_ RELATIVELY

ALIGNED \_\_\_ HIGHLY ALIGNED

HOW DOES THIS MAKE YOU FEEL? \_\_\_\_\_

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DO YOU PRAY? \_\_\_\_\_

IF YES, ARE YOU SATISFIED WITH YOUR PRAYER LIFE? \_\_\_\_\_ IF NOT, WHY

NOT? \_\_\_\_\_

DO YOU MEDITATE? \_\_\_\_\_

IF YES, ARE YOU SATISFIED WITH YOUR MEDITATION PRACTICE? \_\_\_\_\_ IF NOT, WHY NOT?

\_\_\_\_\_

HOW DO YOU NOURISH YOUR SOUL? \_\_\_\_\_

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HOW DO YOU CONNECT WITH THE DIVINE? \_\_\_\_\_

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\_\_\_\_\_ ON A

SCALE OF 1--10 HOW DO YOU RATE THE HEALTH OF YOUR SOUL? \_\_\_\_\_

*Poor 1* \_\_\_\_\_ *10 Excellent*

DO YOU FEEL YOU CAN DO MORE TO NOURISH YOUR SOUL OR SPEND MORE TIME CONNECTING WITH THE DIVINE? \_\_\_\_\_

IF YES, WHY DON'T YOU? \_\_\_\_\_

HOW DO YOUR SPIRIT AND YOUR BODY INTERACT? \_\_\_\_\_

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HOW DOES YOUR SPIRIT INFORM YOUR THOUGHTS AND EMOTIONS? \_\_\_\_\_

\_\_\_\_\_

HOW WELL BALANCED DO YOU FEEL SPIRITUALLY? \_\_\_NOT VERY\_\_\_PRETTY WELL\_\_\_HIGHLY

BALANCED\_\_\_

#### **Map Key #4**

**List the areas of your spirituality which you feel are important to your health:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Why are these important to you?**\_\_\_\_\_

\_\_\_\_\_

**What would you like to do to improve your spiritual health?**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Update Map Key #1 with any additional spiritual problems you have uncovered**

### **Environment Questions and Exercises—Map Key #5**

The territory you are traveling in is pretty complicated. Your world has many unique features.

Let's look around and examine them in some more detail.

LOOK, LISTEN, SMELL AND TOUCH WHERE YOU ARE RIGHT AT THIS MOMENT.

IS IT VISUALLY PLEASING? \_\_\_\_\_ MESSY AND CHAOTIC? \_\_\_\_\_

ARE THE SOUNDS AROUND YOU SOOTHING OR DO YOU NEED TO BLOCK THEM OUT? \_\_\_\_\_

ARE THE SMELLS GOOD AND COMFORTING OR UNPLEASANT? \_\_\_\_\_

DO YOU FREQUENTLY BREATHE ARTIFICIAL SMELLS OR CHEMICALS? \_\_\_\_\_

IS THE PLACE YOU ARE IN SOMEWHERE YOU WANT TO REACH OUT, TOUCH, AND EXPLORE? \_\_\_\_\_

ASK THE SAME QUESTIONS ABOUT PLACES WHERE YOU LIVE--YOUR BEDROOM, KITCHEN, FAMILY ROOM, ETC. WHAT DO YOU CONCLUDE ABOUT HOW HEALTHY THESE PLACES ARE?

\_\_\_\_\_

\_\_\_\_\_

HOW ABOUT YOUR WORK ENVIRONMENT? \_\_\_\_\_ HOW ABOUT YOUR CAR? \_\_\_\_\_

DO THEY COMFORT YOUR SENSES OR OFFEND THEM? \_\_\_\_\_

NATURAL LIGHTING IS HEALTHIER THAN ARTIFICIAL. HOW DO YOU LIGHT THE WORLD AROUND YOU? \_\_\_\_\_

DO YOU THINK IT'S IMPORTANT TO TRY AND MAKE YOUR PHYSICAL ENVIRONMENT AS HEALTHY AS YOU POSSIBLY CAN? \_\_\_\_\_

WHAT DO YOUR SENSES TELL YOU ABOUT THE DIFFERENT PHYSICAL ENVIRONMENTS WHERE YOU COMMONLY SPEND TIME? \_\_\_\_\_

**5A. Are there things you can do to make these places healthier? List them now:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

ON A SCALE OF 1--10 RATE YOUR VIEW OF THE WORLD AROUND YOU.

*Scary/Threatening* **1** \_\_\_\_\_ **10** *Safe/Nurturing*

WHAT IS YOUR SOCIOECONOMIC STATUS? \_\_\_\_\_ YOUR RACE? \_\_\_\_\_ YOUR ETHNIC  
BACKGROUND? \_\_\_\_\_

DO YOU BELONG TO ANY COMMUNITY GROUPS OR ORGANIZATIONS? \_\_\_\_\_ IF NOT, WHY  
NOT? \_\_\_\_\_

IS YOUR NEIGHBORHOOD SAFE? \_\_\_\_\_

DO YOU DO ANY VOLUNTEER WORK? \_\_\_\_\_ IF NOT, WOULD YOU BE WILLING TO START  
VOLUNTEERING? \_\_\_\_\_

HOW DO YOU SEE YOURSELF AS HELPING TO IMPROVE THE HEALTH OF YOUR  
COMMUNITY? \_\_\_\_\_

DO YOU THINK YOUR HEALTH WILL BENEFIT FROM HELPING YOUR COMMUNITY? \_\_\_\_\_

**5B. List some social and cultural factors which affect your health and how you think about health and why these are important to you (if you are struggling to answer this, review the section on environment):**

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_

**List things you are willing to do to make your neighborhood, community, or the world a better place:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

HOW DO YOU RATE THE QUALITY OF YOUR RELATIONSHIPS IN GENERAL? \_\_\_\_ POOR  
\_\_\_\_ FAIR \_\_\_\_ GOOD

IF YOU WERE ILL, DO YOU HAVE FRIENDS OR FAMILY CLOSE BY WHO WOULD HELP YOU AND/OR CHECK ON YOU? \_\_\_\_\_

*Some of the following questions may not apply to everyone*

DESCRIBE THE QUALITY OF YOUR RELATIONSHIP WITH YOUR SPOUSE OR SIGNIFICANT

OTHER: \_\_\_\_\_

ARE THERE AREAS OF ONGOING CONFLICT? \_\_\_\_\_

HOW DO THESE CONFLICTS RELATE TO DIFFERENT EXPECTATIONS IN YOUR RULEBOOKS OF BEHAVIOR? \_\_\_\_\_

\_\_\_\_\_

HAVE YOU DUG IN TO YOUR POSITION? \_\_\_\_\_ RETREATED? \_\_\_\_\_

WOULD YOU LIKE THIS RELATIONSHIP TO BE BETTER? \_\_\_\_\_

DO YOU THINK YOUR HEALTH WOULD BENEFIT IF THIS RELATIONSHIP WAS BETTER? \_\_\_\_\_

WHAT ARE YOU DOING TO MAKE IT BETTER? \_\_\_\_\_

DESCRIBE THE QUALITY OF YOUR RELATIONSHIPS WITH YOUR BOSS AND/OR

COWORKERS: \_\_\_\_\_

WHAT AREAS OF CONFLICT CAN YOU IDENTIFY? \_\_\_\_\_

WHAT ARE YOU DOING TO HELP RESOLVE THESE CONFLICTS? \_\_\_\_\_

\_\_\_\_\_

DESCRIBE THE QUALITY OF YOUR RELATIONSHIPS WITH YOUR PARENTS, SIBLINGS, AND

CHILDREN. \_\_\_\_\_

LIST AREAS OF CONFLICT: \_\_\_\_\_

\_\_\_\_\_

WOULD YOU LIKE ANY OF THESE RELATIONSHIPS TO BE BETTER? \_\_\_\_\_

THINK OF PEOPLE YOU ARE FEELING ANGRY TOWARDS, DON'T LIKE, FEEL HURT BY, OR IN SOME WAY FEEL NEGATIVE ABOUT. WHY DO YOU FEEL THAT WAY TOWARDS THOSE INDIVIDUALS?

\_\_\_\_\_

\_\_\_\_\_

ARE THERE ANY SIGNIFICANT RELATIONSHIPS (EITHER DETAILED ABOVE OR OTHER) WHICH ARE CAUSING YOU PAIN? \_\_\_\_\_

*Review the section on relationships.*

**5C. List specific relationship issues which you feel affect your health and how they affect your health:**

<b>Issue:</b>	<b>Affect:</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Sections 5A, 5B, and 5C above are your Map Key #5**

**Update Map Key #1 with any additional environmental problems you have uncovered**

### **Final Questions and Exercises—Master Key**

Almost there! This final assessment section is, in some sense, the most difficult because it challenges you to take a hard look at some deeply personal and internal issues. Motivation, addictions, forgiveness, grief, attitudes/perspectives and stress management are important areas to more fully understand when integrally assessing your health. Spend some extra time on this section. Your efforts will be rewarded.



**If not, what needs to change to help you have this discipline?** \_\_\_\_\_  
\_\_\_\_\_

**When your motivation weakens or fails, what strategies will you use in order to persevere or to succeed?** \_\_\_\_\_  
\_\_\_\_\_

**Who will you ask to help you improve your motivation and achieve your goals?**  
\_\_\_\_\_  
\_\_\_\_\_

**LIST THINGS WHICH YOU DO THAT YOU CONSIDER TO BE UNHEALTHY HABITS:** \_\_\_\_\_  
\_\_\_\_\_

**WHAT ACTIVITIES OR SUBSTANCES ARE YOU USING TO COUNTERACT DYSPHORIA OR TO INDUCE EUPHORIA OR IN SOME WAY TO “ESCAPE” THE PRESENT?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHAT UNDERLYING STATE OR STATES ARE YOU TRYING TO CHANGE?**  
\_\_\_\_\_  
\_\_\_\_\_

PLACE A CHECK MARK NEXT TO ANY THAT REPRESENT ADDICTIONS.

PLACE A STAR NEXT TO ANY THAT REPRESENT UNHEALTHY CHOICES.

CIRCLE ANY CHECKED OR STARRED ITEMS THAT YOU ARE MOTIVATED TO CHANGE.

FOR ANY CHECKED OR STARRED ITEMS YOU HAVE NOT CIRCLED, WHY ARE YOU NOT MOTIVATED TO CHANGE YOUR BEHAVIOR? \_\_\_\_\_  
\_\_\_\_\_



LIST HEALTHIER WAYS FOR YOU TO DEAL WITH SITUATIONS YOU ARE TRYING TO ESCAPE OR STATES

YOU ARE TRYING TO CHANGE: \_\_\_\_\_

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**Update section 6A with any additional goals pertaining to unhealthy habits or addictions.**

LIST PEOPLE AND/OR SITUATIONS WHICH HAVE CAUSED YOU HURT THAT YOU HAVE NOT YET

FORGIVEN: \_\_\_\_\_

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CONSIDER TIMES IN YOUR LIFE WHEN YOU HAVE CHOSEN NOT TO FORGIVE. WHAT HAS BEEN THE

RESULT/IMPACT OF THIS CHOICE? \_\_\_\_\_

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HOW IS FAILING TO FORGIVE CONTRIBUTING TO YOUR SUFFERING? \_\_\_\_\_

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DO YOU THINK THE CHOICE TO FORGIVE WILL BENEFIT YOUR HEALTH? \_\_\_\_\_

WHAT ARE YOUR CURRENT STRATEGIES FOR FORGIVENESS? \_\_\_\_\_

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DO THEY WORK? \_\_\_\_\_

LIST ANY AREAS OF SELF-FORGIVENESS WHICH YOU WOULD LIKE TO WORK ON: \_\_\_\_\_

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HOW COULD AN ATTITUDE OF FORGIVENESS REDUCE WORLD CONFLICT AND IMPROVE THE WORLD

IN WHICH WE LIVE? \_\_\_\_\_

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HOW CAN YOU CONTRIBUTE TO THIS? \_\_\_\_\_

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**6B. List anything you feel you need to forgive. This applies to self, God, other people, life or world circumstances:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**For any item listed above for which you are not willing at this time to choose forgiveness, why do you choose not to forgive?**

- \_\_\_\_\_
- \_\_\_\_\_

**Does this bring you peace? \_\_\_\_\_**

**Update Section 6A with any additional goals related to forgiveness.**

LIST BELOW SIGNIFICANT LOSSES YOU HAVE EXPERIENCED WHICH YOU THINK MAY BE AFFECTING YOUR HEALTH TODAY: \_\_\_\_\_

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WHAT LOSSES ARE YOU STILL GRIEVING? \_\_\_\_\_

\_\_\_\_\_

HOW DO YOU RESPOND TO LOSS? \_\_\_\_\_

\_\_\_\_\_

WHAT SOCIAL AND/OR CULTURAL ISSUES AFFECT YOUR ABILITY TO GRIEVE? \_\_\_\_\_

\_\_\_\_\_

DETAIL BELOW ANY SIGNIFICANT PHYSICAL, EMOTIONAL, OR SPIRITUAL TRAUMA YOU HAVE

EXPERIENCED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLACE A CHECK NEXT TO ANY ITEM ABOVE WHICH STILL REQUIRES YOUR FORGIVENESS.

PLACE A STAR NEXT TO ANY ITEM ABOVE WHICH REPRESENTS AN AREA OF UNRESOLVED GRIEF.

**6C. From what you have learned about grief, list ways you can improve your health in dealing with loss:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Update Section 6A with any additional goals related to grief.**

DO YOU BELIEVE THAT YOU CAN ENJOY GOOD HEALTH? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

---

DO YOU SEE YOURSELF AS A HEALTHY PERSON? \_\_\_\_\_

IF NOT, WHY NOT? \_\_\_\_\_

DO YOU BELIEVE IN THE “POWER OF POSITIVE THINKING”? \_\_\_\_\_

WHAT BELIEFS ABOUT YOUR HEALTH DO YOU HAVE WHICH YOU THINK ARE UNHEALTHY?

\_\_\_\_\_  
\_\_\_\_\_

DO YOU FREQUENTLY SEE YOURSELF AS A VICTIM? \_\_\_\_\_

DO YOU BLAME OTHER PEOPLE OR EXTERNAL CIRCUMSTANCES FOR YOUR PROBLEMS? \_\_\_\_\_

WHAT UNHEALTHY INTERNAL PROGRAMMING OR RESPONSE PATTERNS ARE YOU AWARE

OF? \_\_\_\_\_

\_\_\_\_\_  
HOW CAN YOU CHANGE THESE? \_\_\_\_\_

\_\_\_\_\_  
ARE YOU MOTIVATED TO MAKE THESE CHANGES? \_\_\_\_\_ IF NOT, WHY NOT? \_\_\_\_\_

\_\_\_\_\_  
WHO CAN YOU ASK TO HELP YOU MAKE THESE CHANGES? \_\_\_\_\_

\_\_\_\_\_  
WOULD YOU LIKE TO HAVE A MORE POSITIVE ATTITUDE ABOUT YOUR HEALTH? \_\_\_\_\_

WHAT CAN YOU DO TO PROMOTE THIS? \_\_\_\_\_

\_\_\_\_\_

**6D. What aspects of beliefs, attitudes, or perspectives about your health are areas which you would like to improve?**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Update Section 6A with any additional goals related to attitude and perspective.**

HOW DO YOU THINK STRESS IS AFFECTING YOUR HEALTH? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU SOMETIMES FEEL OVERWHELMED BY STRESS? \_\_\_\_\_

DO THE STRESSORS IN YOUR LIFE LEAVE YOU FEELING DISEMPOWERED OR “OUT OF CONTROL”?  
\_\_\_\_\_

IS IT IMPORTANT TO YOU TO FEEL “IN CONTROL” OF YOUR LIFE? \_\_\_\_\_

WHAT HAPPENS WHEN YOU NO LONGER FEEL IN CONTROL? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST EXTERNAL FACTORS WHICH YOU FEEL ARE STRESSORS IN YOUR LIFE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST INTERNAL FACTORS WHICH YOU FEEL ARE STRESSORS IN YOUR LIFE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IN THE ABOVE LISTS, CIRCLE EXTERNAL AND INTERNAL STRESSORS WHICH YOU FEEL YOU CAN CHANGE.

FOR THE ITEMS CIRCLED, EXPLAIN THINGS THAT YOU CAN DO TO CHANGE THINGS FOR THE BETTER:

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WHAT CURRENT STRATEGIES ARE YOU USING TO MANAGE STRESS? \_\_\_\_\_

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HOW WELL ARE THEY WORKING? \_\_\_\_\_

FROM THE PRECEDING LIST, PLACE AN “X” THROUGH ANY STRATEGIES WHICH YOU JUDGE TO BE UNHEALTHY CHOICES TO HELP YOU COPE.

**6E. List Body, Mind, Spirit, and Environmental things you can do to better manage your stress. This can include eliminating certain stressors in addition to selecting healthy choices to help you cope with the stressors in your life.**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**What prevents you from doing the things on the list above more or more often?**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Who can you obtain help from in your efforts to better manage stress?**

- \_\_\_\_\_
- \_\_\_\_\_

**Update Section 6A with any additional goals related to stress management**

**Sections 6 A thru E above are your Map Key #6**

**Update Map Key #1 with any additional problems you have uncovered during your answers to the questions about motivation, addictions, forgiveness, grief, attitudes/perspectives, and stress management.**

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**Summarize Your Health Issues:**

**1. Describe what it means to you to be healthy:**

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**2. What parts of yourself do you see as ill?**

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**3. What parts of you do you see as healthy?**

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**4. What physical issues are causing you pain/suffering?**

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**5. What mental/emotional issues are causing you pain/suffering?**

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**6. What spiritual issues are causing you pain/suffering?**

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**7. What environmental issues (include relationships) are causing you pain/suffering?**

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**8. Look in a mirror and study yourself for a few minutes.**

**In terms of your physical health, what do you see?**

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**Look deeper to your mental and emotional health. What do you see?**

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**Look deeper to the health of your soul and spirit. What do you see?**

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**9. What connections do you make between disease and illness?**

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**10. What connections do you make between pain and suffering?**

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**11. What do you believe is wrong with you?**

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Review your 6 **Map Keys**. Pay particular attention to Map Key #1 and #6A (you should have been updating these throughout the various assessments).

Review your answers to the eleven questions above. Now list the most important health issues which you feel are affecting your health. List only one health issue per line. Your list can be as long or as short as you like. All of the items listed will be represented on your map. In the column on the right, indicate what part of you--body, mind, or spirit this issue affects the most.

