

Beliefs List

Patient Information

Name:

Age:

Date:

This template is designed to help patients identify and reflect on their core beliefs, which can influence thoughts, emotions, and behaviors.

Core Beliefs about Self

Describe your fundamental beliefs about yourself:

Beliefs about Others

Describe your fundamental beliefs about other people:

Beliefs about the World

Describe your fundamental beliefs about the world:

Influential Life Experiences

List any significant life events that have shaped your beliefs:

Challenging and Reinforcing Beliefs

Identify beliefs that you would like to challenge or change:

Identify beliefs that you strongly hold and reinforce your values:

Impact of Beliefs on Daily Life

How do these beliefs affect your daily life and decision-making?

Goals for Belief Modification

What beliefs would you like to modify or develop for your well-being?

Health Professional's Observations and Details

Observations and Recommendations:

Name of Health Professional and Signature

Name of Health Professional:

Name of Practice: