

Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Sex: _____ Referred By: _____

Marital Status: Single: ____ Engaged: ____ Married: ____ Separated: ____ Divorced: ____ Widowed: ____

Education (last year completed): _____

Primary Phone: _____ Secondary Phone: _____

Employer: _____ Position: _____

Years at Employer: _____ E-MAIL: _____

Is English your first language: _____ If not, what is: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ Years at Employer: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Date of Marriage: _____ Length of Dating: _____

Give a brief statement of circumstances of meeting and dating: _____

Is your spouse willing to come for counseling: _____ If not, please explain: _____

Is your spouse in favor of your coming: _____ If not, please explain: _____

Have either of you been previously married: _____ If so, to whom: _____

Have you ever been separated: _____ Have you ever filed for divorce: _____

If there have been multiple marriages, briefly explain time frames, children involved, and reasons: _____

Information about Children:

Name: Age: Sex: Living: Year Ed.: Biological:

Are you in a significant relationship other than marriage? Explain and include how long: _____

Describe relationship to your father: _____

Describe relationship to your mother: _____

Rate your parents' marriage: ____ unhappy ____ average ____ happy ____ very happy

Are/were your parents divorced? If so, explain when, and the basic circumstances: _____

Did you live with anyone other than your parents growing up? _____

Check all the following that best describe the parenting style of your childhood (M = Mother, F = Father)

Excessively authoritative / Very high control

M_____

F_____

Excessively permissive / Too low control

M_____

F_____

Generally balanced leadership / Authority

M_____

F_____

Manipulative (selfish, angry, guilt trip)

M_____

F_____

Leading by example

M_____

F_____

Rules / Instructions without relationship

M_____

F_____

Disengaged / Excessively preoccupied

M_____

F_____

Caring involvement / Instruction

M_____

F_____

Perfectionistic / Very performance driven

M_____

F_____

Check all the following that best describe the predominant atmosphere(s) in your home as a child

Happy_____

Sad/Depressing_____

Calm/Relaxed_____

Secure/Safe_____

Tumultuous/Uncertain_____

Angry/Hostile_____

Open/Honest_____

Closed off/Private_____

Loving/Encouraging_____

Truly Christian_____

Outwardly-religious_____

Non-Christian_____

Other_____

Was there any substance abuse in your family? If yes, please explain:_____

Number of sibling(s): _____ Birth order of all siblings: _____

Are your parents living: _____ Do they live locally: _____

Has there been any abuse in your past? Physical _____ Verbal/Emotional _____ Sexual _____ No _____

If yes, by whom and at what age? _____

Health

Describe your health: _____

Do you have any chronic conditions: _____ What: _____

List important illnesses and injuries or handicaps: _____

Date of last medical exam: _____ Report: _____

Physician's name and address: _____

Current medication(s) and dosage (include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, etc.): _____

Have you ceased taking any drugs recently? Which ones, why, and when? _____

Have you ever used drugs for anything other than medical purposes: _____

If yes, please explain: _____

Have you ever been arrested: _____ if so, why, when and was there a resulting sentence: _____

Do you drink alcoholic beverages: _____ If so, how frequently and how much: _____

Do you drink coffee: _____ How much: _____ Other caffeine drinks: _____

How much: _____

Do you smoke: _____ What: _____ Frequency: _____

On a scale of 1-10, how healthy do you eat (10 being the healthiest)? _____

How many hours of sleep do you average each night? _____

Has there been any recent change? Is this sleep uninterrupted? _____

Have you ever experienced hallucinations, seen distorted faces, or heard voices? If yes, please explain: _____

How often do you exercise (times a week)? _____

Have you ever had interpersonal problems on the job: _____

Have others noticed any significant changes in your emotional or mental state, memory, or work abilities?

If yes, please explain: _____

Have you ever had a severe emotional upset: _____ If yes, please explain: _____

Have you ever seen a psychiatrist or counselor: _____ If yes, please explain: _____

If yes, what were you seen for and for how long? _____

If you received a diagnosis or treatment, please explain: _____

If you carry significant guilt, explain why: _____

Are you willing to sign a release of information form so that your counselor may write for social,

psychiatric, or other medical records: _____

Spiritual

Denominational preference: _____

Church attending: _____

Location: _____ Are you a member: _____

Pastor's Name: _____ Pastor's Phone Number: _____

Do we have permission to contact your Pastor: _____

Church attendance per month (circle): 0 1 2 3 4 5 6 7 8+

Are you part of a small group? Yes _____ No _____

Do you believe in God? _____ Do you pray? _____ If so, how often do you pray? _____

Do you consider yourself as “saved” (a Christian?): _____

If you’re not a Christian, are you interested in becoming a Christian?: _____

Have you come to the place in your spiritual life where you know with certainty that you would enter heaven after death? _____

If you were to die and stand before God and He asked you why He should permit you to enter heaven, how might you respond? _____

Have you ever been baptized: _____

How often do you read the Bible: Never: _____ Occasionally: _____ Often: _____ Daily: _____

Explain any recent changes in your spiritual life: _____

Women Only

Have you had an unplanned pregnancy: _____ Have you ever had an abortion: _____

Did you suffer any medical side-effects, that would be helpful for your counselor to know:

Have you had any menstrual difficulties: _____ If you experience tension, tendency to cry, other symptoms prior to your cycle, please explain: _____

Problem Check List

_____ Abuse	_____ Communication	_____ Finances	_____ Memory
_____ Addiction	_____ Conflict (fights)	_____ Gambling	_____ Mental Confusion
_____ Adultery	_____ Cutting	_____ Gluttony	_____ Moodiness
_____ Anger	_____ Deception	_____ Grief	_____ Overwhelmed
_____ Anorexia	_____ Decision Making	_____ Guilt	_____ Perfectionism
_____ Anxiety	_____ Depression	_____ Health	_____ Procrastination
_____ Apathy	_____ Drastic life changes	_____ Homosexuality	_____ Rebellion
_____ Bitterness	_____ Drunkenness	_____ Infertility	_____ Sex
_____ Bulimia	_____ Drugs	_____ In-laws	_____ Sleep
_____ Change in lifestyle	_____ Envy	_____ Loneliness	_____ Unbiblical Habit
_____ Children	_____ Fear	_____ Lust/Pornography	_____ Unresolved Past
_____ Other: If you selected "other," what is the specific problem? _____			

Pre-Counseling Questions

Please take some time to think through what has been happening in your life that brings you to counseling. This section will help us get to know your current situation better, in order to match you with a counselor and/or provide the best help. Use the following questions as a guide to journal about what is going on in your life and heart.

1. What has brought you here? Describe the main problem in your life as you see it. (Include when it began and any other very significant events or information.)

2. What have you done to try and resolve the problem on your own?

3. Why are you now wanting to seek help?

4. What types of thoughts come to your mind in your current situation when you feel disappointed, discouraged, angry and/or fearful about the situation?

5. What are you hoping we can do for you?

6. Is there any other information you think we should know?