DATE_______________ FILE #_____________________________

PERSONAL DATA INVENTORY

Counseling appointments are available:
TUES thru THURS 9:00am - 7:00pm / FRI 9:00am - noon
☐ *If you are in need of appointment outside of these times, please check the box.*

Personal Identification

Name: ____ Birth Date:____________

Address: ____ Zip Code:______________

Age: _______ Sex: ______ Referred by:____

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

Education (last year completed): ____

E-Mail:___________________________________ Best Contact Phone: ____________________

Employer: ________________________________ Position:____________________ Years:____

Marriage and Family

Spouse: ____ Birth Date:____________

Age: _______ Occupation: ________________________________ How long employed:____________

Home Phone: __________________________ Work Phone: __________________________

Date of Marriage:__________ Length of Dating:_____________ Give a brief statement of circumstances of meeting and dating:

____

____

____

____

Have either of you been previously married?____________ To whom?______________________________

Have you ever been separated?_________ Filed for divorce?__________

Is spouse willing to come for counseling? NO YES Uncertain

Information about Children:

Name	Age	Sex	Where Living	Grade	Step-Child Y/N

Describe relationship to your father: ____

____

Describe relationship to your mother: ____

____

Number of sibling(s): ___________ Your place in sibling order:______________

Did you live with anyone other than parents?____________________________________

Are your parents living?_________________________ Do they live locally?____________________________

Health

Rate your health (check): Very Good Good Average Declining Other______________________________

Weight changes recently: Lost_______________ Gained_______________

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:____

____

Have you ever used drugs for anything other than medical purposes?__________ If yes, please explain:

____

____

Have you ever been arrested?____

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:_______________

Have you ever had interpersonal problems on the job?____

____

Have you ever had a severe emotional upset? _________ If yes, please explain: ______________________________

____

Have you ever seen a psychiatrist or counselor? ________ If yes, please explain: ____________________________

____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records?________

Spiritual

Church attending:______________________________________ Pastor's Name:__________________________

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

Do you attend a Home Church or Small Group?____

Do you believe in God?_________ Do you pray?_________ Would you say that you are a Christian?________

Or still in the process of becoming a Christian?_________ Have you ever been baptized?_________

How often do you read the Bible? Never Occasionally Often Daily

Explain any recent changes in your religious life:____

____

Are you involved in some kind of ministry at your church or elsewhere?_______________________________

Do you financially support your church on a regular basis? Yes No

Women Only

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

Is your husband willing to come for counseling?________ Is he in favor of your coming?_____ If no, please explain:

____

____

Problem Check List

- ❑ Anger
- ❑ Anxiety
- ❑ Apathy
- ❑ Appetite
- ❑ Bitterness
- ❑ Change in lifestyle
- ❑ Children
- ❑ Communication
- ❑ Conflict (fights)
- ❑ Deception
- ❑ Decision Making
- ❑ Depression
- ❑ Drunkenness
- ❑ Envy
- ❑ Fear
- ❑ Finances
- ❑ Gluttony
- ❑ Guilt
- ❑ Health
- ❑ Homosexuality
- ❑ Impotence
- ❑ In-laws
- ❑ Loneliness
- ❑ Lust
- ❑ Memory
- ❑ Moodiness
- ❑ Perfectionism
- ❑ Rebellion
- ❑ Sex
- ❑ Sleep
- ❑ Wife Abuse
- ❑ A Vice
- ❑ Other

Briefly answer the following questions:

1. What circumstances led to your coming here at this point in time?______________________________

____

____

____

2. What have you done about the problem?____

____

____

____

3. What are your expectations from counseling?____

____

____

4. Is there any other information that we should know?____________________________________

____

____