The Biblical Counseling Ministry
Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Gender: _____ Referred By: _____

Marital Status (circle): ☐ Single ☐ Engaged ☑ Married ☐ Separated ☐ Divorced ☐ Widowed

Education (last year completed): _____

Home Phone: _____ Other Phone: _____

Employer: _____ Position: _____

Years: _____ Attend School: _____ Weekly Work/School hours: _____

Hobbies: _____

Other significant time/financial commitments: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ How Long Employed: _____

Home Phone: _____ Other 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: _____

Information about Children:

Name:	Age:	Gender:	Living:	Year Ed.:	Step-Child:

Describe relationship to your father: _____

_____

Describe relationship to your mother: _____

_____

Number of sibling(s): _____ Your sibling order: _____

Do you or have you lived with anyone other than parents: _____

_____

Parents still married: _____ Parents living: _____ Parents live locally: _____

Parent's religious convictions, were/are they believers: _____

_____

_____

Health

Describe your overall health: _____

_____

Describe any chronic conditions, important illnesses, injuries, or handicaps: _____

_____

_____

_____

Date of last medical exam: _____ Report: _____

Do you have a family doctor or physician you see regularly? _____

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: _____

Use Tobacco: _____ What: _____ Frequency: _____

Describe your normal sleeping schedule: _____

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 (if needed): _____

Spiritual

Denominational preference: _____

Church attending: _____ Member: _____

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

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

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: _____ Are you involved in ministry: _____

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

Have you ever been discipled? If yes, please describe: _____

_____

Explain any recent changes in your religious life: _____

_____

What are the three biggest positive influences on your spiritual life:_____

_____

What are the three biggest negative influences on your spiritual life:_____

_____

Have you shared the problems for which you are seeking counseling with your pastor and/or other mature members of your church? If yes, please write down their names. If no, please describe any concerns you have about doing so: _____

_____

_____

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 Checklist: Please rate how these items impact your life

(blank) = no significant impact; 1 = mild impact; 2 = moderate impact; 3 = severe impact

_____ Adultery
_____ Anger
_____ Anorexia/Bulimia
_____ Anxiety
_____ Apathy
_____ Bitterness
_____ Children
_____ Childhood Sexual Abuse
_____ Communication
_____ Conflict (fights)
_____ Control
_____ Critical Spirit
_____ Deception
_____ Decision Making
_____ Depression
_____ Disciplined Living
_____ Disorganization
_____ Discouraged/ Downcast
_____ Drunkenness
_____ Dysfunctional Family
_____ Envy
_____ Fear
_____ Finances
_____ Gluttony
_____ Grief
_____ Guilt
_____ Health
_____ Impotence
_____ In-laws
_____ Jealousy
_____ Laziness
_____ Loneliness
_____ Lust
_____ Marriage
_____ Moodiness
_____ Overwhelmed/ Stress
_____ Perfectionism
_____ Pornography
_____ Procrastination
_____ PTSD
_____ Rebellion
_____ Rejection
_____ Sexual Immorality
_____ Sexual Dysfunction
_____ Sleep
_____ Spouse Abuse
_____ Suicidal Thoughts
_____ Weariness

_____ Other

Briefly Answer The Following Questions

1. Why have you sought counseling? What difficulties are you facing?

2. What have you done about the difficulties?

3. What are your expectations from counseling?

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