Personal Data Inventory

Personal Identification

Today's Date:_____

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Sex: _____ Referred By: _____

Marital Status: Single Engaged Married Separated Divorced Widowed

Education (last year completed): _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Position: _____

Years at Current Employer: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ How Long Employed:? _____

Cell Phone: _____ 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?: _____

Information about Children:

Name	Age	Sex	Living?	Year Education:	Step-Child?

Describe relationship to your father: _____

Describe relationship to your mother: _____

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

Name	Age	Sex	Living?	Year Education:	Step-sib?

Did you live with anyone other than parents: _____

Are your parents living?: _____ In what city/state do they live?: _____

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: _____

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

Denominational preference: _____

Name of Church attending: _____ Member: Yes No

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: _____

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

Explain any recent changes in your religious life: _____

In which ministries are you involved?_____

If you attend a bible study or a fellowship group, please describe briefly:_____

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	_____Depression	_____Loneliness
_____Anxiety	_____Drunkenness	_____Lust
_____Apathy	_____Envy	_____Memory
_____Appetite	_____Fear	_____Moodiness
_____Bitterness	_____Finances	_____Perfectionism
_____Change in lifestyle	_____Gluttony	_____Rebellion
_____Children	_____Guilt	_____Sex
_____Communication	_____Health	_____Sleep
_____Conflict (fights)	_____Homosexuality	_____Wife abuse
_____Deception	_____Impotence	_____A Vice
_____ Decision Making	_____In-laws	_____Other

If Other, please describe: _____

Briefly Answer The Following Questions

1. What is your problem (what brings you here)?

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?