

Personal Data Inventory Form

Personal Data

Name:		Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street)		(City)	(State)	(Zip)
Home Phone#:	Cell Phone#:	Business Phone#:	Occupation	
Email Address:		Education/Training: (Highest Level Achieved/Major/Licensing)		Degree Earned (If applicable)
Referred for counseling by:				
Have you ever been arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times?		Dates:	Please write the details of any arrest(s) on page 7.	

Family History

Father's Name:	Age:	Occupation:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Religious Affiliation:		Monthly Church Attendance:	Still Living? <input type="checkbox"/> Yes <input type="checkbox"/> No

Mother's Name:	Age:	Occupation:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Religious Affiliation / Church:		Monthly Church Attendance:	Still Living? <input type="checkbox"/> Yes <input type="checkbox"/> No

How old were you when your parents divorced?

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Describe your parent's marriage – check all that apply: <input type="checkbox"/> Fighting – Anger – Threats <input type="checkbox"/> Yelling – Hurtful Words	<input type="checkbox"/> Little or no showing of affection <input type="checkbox"/> Very little communication <input type="checkbox"/> Cold <input type="checkbox"/> Abusive	<input type="checkbox"/> Happy <input type="checkbox"/> Unhappy
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How did you feel during childhood? Check all that apply: <input type="checkbox"/> Very Unhappy <input type="checkbox"/> Angry <input type="checkbox"/> Rebellious <input type="checkbox"/> Lonely	<input type="checkbox"/> Depressed <input type="checkbox"/> Fearful <input type="checkbox"/> Had lots of friends <input type="checkbox"/> Had very few friends <input type="checkbox"/> Happy – Non-Christian Home <input type="checkbox"/> Unhappy – Non-Christian Home	<input type="checkbox"/> Happy christian home <input type="checkbox"/> Unhappy christian home Which parent/other were you closest to? <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other Who: _____
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Brothers and Sisters

(If there are more, please attach a separate sheet.)

#1 Name:	Age:	Relationship: <input type="checkbox"/> Brother <input type="checkbox"/> Step Brother <input type="checkbox"/> Sister <input type="checkbox"/> Step Sister	Marital Status:	State of residence:
#2 Name	Age:	Relationship: <input type="checkbox"/> Brother <input type="checkbox"/> Step Brother <input type="checkbox"/> Sister <input type="checkbox"/> Step Sister	Marital Status:	State of residence:
#3 Name:	Age:	Relationship: <input type="checkbox"/> Brother <input type="checkbox"/> Step Brother <input type="checkbox"/> Sister <input type="checkbox"/> Step Sister	Marital Status:	State of residence:
#4 Name:	Age:	Relationship: <input type="checkbox"/> Brother <input type="checkbox"/> Step Brother <input type="checkbox"/> Sister <input type="checkbox"/> Step Sister	Marital Status:	State of residence:

Work History

Jobs you have held in the past 5 years, dates of employment, and reasons for leaving.

Does your current work satisfy you? Please explain why or why not.

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Marital Status

Current Status

<input type="checkbox"/> Single	<input type="checkbox"/> Engaged	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Remarried	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
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When:

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How long did you date?

How long were you engaged?

Spouse's Name	Age	Cell Phone # Business Phone#: Email address:	Previously Married? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times?	Occupation:
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Describe your current marriage – check all that apply: <input type="checkbox"/> Fighting – Anger – Threats <input type="checkbox"/> Yelling – Hurtful Words	<input type="checkbox"/> Little or no showing of affection	<input type="checkbox"/> Unhappy
	<input type="checkbox"/> Very little communication	<input type="checkbox"/> Happy
	<input type="checkbox"/> Cold	<input type="checkbox"/> Loving
<input type="checkbox"/> Abusive	<input type="checkbox"/> Peaceful	

Other Significant History

Please list any history of mental, emotional, psychological, or sexual suffering that would help us to understand you better.

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Children

(If there are more, please attach a separate sheet.)

Name:	Age:	Relationship: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Previous Relationship <input type="checkbox"/> Step Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Other _____	Living in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Grade in school:
Name:	Age:	Relationship: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Previous Relationship <input type="checkbox"/> Step Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Other _____	Living in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Grade in school:
Name:	Age:	Relationship: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Previous Relationship <input type="checkbox"/> Step Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Other _____	Living in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Grade in school:
Name:	Age:	Relationship: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Previous Relationship <input type="checkbox"/> Step Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Other _____	Living in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Grade in school:
Name:	Age:	Relationship: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Previous Relationship <input type="checkbox"/> Step Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Other _____	Living in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Grade in school:

Religious Background

Name of Church Currently Attending:	Address of Church Currently Attending:	
Denomination/Affiliation:	Church Phone#	Pastor's Name:
Denomination/Affiliation/Church while you were growing up:		

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Current church attendance per month: <input type="checkbox"/> Not at all <input type="checkbox"/> Whenever I feel like it <input type="checkbox"/> 2 to 3 times <input type="checkbox"/> Every Sunday	Do you believe in God? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you pray to God? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you pray? <input type="checkbox"/> Not at all <input type="checkbox"/> Seldom <input type="checkbox"/> Regularly <input type="checkbox"/> Daily	Has your praying changed recently? <input type="checkbox"/> No change <input type="checkbox"/> Less <input type="checkbox"/> More
Are you saved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Please write your testimony of salvation on page 7	How often do you read your Bible? <input type="checkbox"/> Not at all <input type="checkbox"/> Seldom <input type="checkbox"/> Regularly <input type="checkbox"/> Daily	Which translation(s) do you prefer?	Do you believe the entire Bible is true and without errors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Has your Bible reading changed recently? <input type="checkbox"/> No change <input type="checkbox"/> Increased <input type="checkbox"/> Decreased

Medical History

What physical problems have you had, or currently have? Check all that apply.

<input type="checkbox"/> Heart problems	<input type="checkbox"/> Thyroid dysfunction	<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Liver problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Change in sexual drive
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Recent weight changes	<input type="checkbox"/> Problems walking
<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Impotence	<input type="checkbox"/> Unusual hair loss
<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies	<input type="checkbox"/> Physical changes	<input type="checkbox"/> Rashes
<input type="checkbox"/> Seizures	<input type="checkbox"/> Cancer	<input type="checkbox"/> Constant hunger	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Fevers	<input type="checkbox"/> Personality changes
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Visual distortions	<input type="checkbox"/> Infections	<input type="checkbox"/> Blackouts
<input type="checkbox"/> Weakness	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Amnesia	<input type="checkbox"/> Tremors
<input type="checkbox"/> Heat/cold sensitivity	<input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Headaches	<input type="checkbox"/> Other

List all prescriptions and over-the-counter-medications you are currently taking. Please list dosage and frequency. (over-the-counter medication examples: diet pills, laxatives, birth control pills, cold & allergy medications, etc.)

Have you used drugs for other than medical purposes? Yes No If yes, explain.

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Health Information

List all important present or past illnesses, injuries, handicaps, or anything else that is affecting your health. Please include past or present addictions.

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Date of last medical exam:	Reason:	Physician:
When was your last OB/GYN exam?		

Have you ever had severe emotional upsets?	Have you had psychotherapy, psychological, or any other counseling?
With whom?	Results:
Date(s) of counseling:	

Miscellaneous

What is your favorite verse/passage in the Bible?	Why?
What is your favorite song or group (this doesn't have to be religious)?	Why?
Do you have any hobbies?	If so, what are they?

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Please write the details of any arrest(s) here, if applicable.

Please write your testimony of salvation here. **(If you need more room, please attach a separate sheet.)**

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What is/are the problem(s) that bring you here?

State in your own words what the main problem(s) is/are from your point of view.

What have you done about it?

What are your expectations in coming here? How are you going to evaluate/measure success?

Please review the Consent to Counseling document.

Please sign and date it.

If you have any questions, please see the Director of the Center.