

Please Note: There are three pages to this form.

## PERSONAL DATA INVENTORY

### IDENTIFICATION DATA

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Email address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Marital Status:

Single \_\_\_ Going Steady \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Education (last year completed) \_\_\_\_\_ Other training (list type and years) \_\_\_\_\_

Referred here by \_\_\_\_\_ Address \_\_\_\_\_

Phone # of person referring \_\_\_\_\_

### HEALTH INFORMATION

Rate your health (check): Very Good \_\_\_ Good \_\_\_ Average \_\_\_ Declining \_\_\_ Other \_\_\_

Weight changes recently: Lost \_\_\_\_\_ Gained \_\_\_\_\_

List all important present or past illnesses, injuries or handicaps: \_\_\_\_\_

Date of last medical examination \_\_\_\_\_ Report: \_\_\_\_\_

Your physician \_\_\_\_\_ Address \_\_\_\_\_

Are you presently taking medication? Yes \_\_\_ No \_\_\_ What \_\_\_\_\_

Have you ever been arrested? Yes \_\_\_ No \_\_\_ State circumstances: \_\_\_\_\_

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or medical report? Yes \_\_\_ No \_\_\_

### RELIGIOUS BACKGROUND

Denominational preference: \_\_\_\_\_ Member \_\_\_\_\_

Church attendance per month (circle) 0 1 2 3 4 5 6 7 8 9 10+

Church attended in childhood \_\_\_\_\_ Baptized? Yes \_\_\_ No \_\_\_

Religious background of spouse (if married) \_\_\_\_\_

Do you consider yourself a religious person? Yes \_\_\_ No \_\_\_ Uncertain \_\_\_

Do you believe in God? Yes \_\_\_ No \_\_\_ Uncertain \_\_\_

Do you pray to God? Yes \_\_\_ No \_\_\_ Uncertain \_\_\_

Are you saved? Yes \_\_\_ No \_\_\_ Not sure what you mean \_\_\_

How frequently do you read the Bible? Never \_\_\_ Occasionally \_\_\_ Often \_\_\_

Do you have regular family devotions? Yes \_\_\_ No \_\_\_

Explain recent changes in your religious life, if any \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MARRIAGE AND FAMILY INFORMATION**

Name of spouse \_\_\_\_\_ Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Your spouse's age \_\_\_\_ Education (in years) \_\_\_\_ Religion \_\_\_\_\_  
 Is spouse willing to come for counseling? Yes \_\_\_\_ No \_\_\_\_ Uncertain \_\_\_\_  
 Have you ever been separated? Yes \_\_\_\_ No \_\_\_\_ When? From \_\_\_\_\_ to \_\_\_\_\_  
 Has either of you ever filed for divorce? Yes \_\_\_\_ No \_\_\_\_ When? \_\_\_\_\_  
 Date of marriage \_\_\_\_\_ Your ages when married: Husband \_\_\_\_ Wife \_\_\_\_  
 How long did you know your spouse before marriage? \_\_\_\_\_  
 Length of steady dating with spouse? \_\_\_\_\_ Length of engagement? \_\_\_\_\_  
 Give brief information about any previous marriages: \_\_\_\_\_

**Information about children:**

PM*	Name	Age	Sex	Living Yes or No	Education in years	Marital Status
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\*check this column if child is by previous marriage

If you were reared by anyone other than you own parents, briefly explain: \_\_\_\_\_

How many older brothers \_\_\_\_\_ sisters \_\_\_\_\_ do you have?  
 How many younger brothers \_\_\_\_\_ sisters \_\_\_\_\_ do you have?  
 Have there been any deaths in the family during the last year? Yes \_\_\_\_ No \_\_\_\_  
 Who and When: \_\_\_\_\_

**PERSONALITY INFORMATION:**

Have you used drugs for other than medical purposes? Yes \_\_\_\_ No \_\_\_\_ What? \_\_\_\_\_  
 Have you ever had a severe emotional upset? Yes \_\_\_\_ No \_\_\_\_ Explain \_\_\_\_\_

Have you ever had any psychotherapy or counseling before? Yes \_\_\_\_ No \_\_\_\_  
 If yes, list counselor or therapist and dates: \_\_\_\_\_

What was the outcome? \_\_\_\_\_

Circle any of the following words that best describe you now: *active ambitious self-confident persistent nervous hardworking impatient impulsive moody often-blue excitable imaginative calm serious easy-going shy good-natured introvert extravert likeable leader quiet hard-boiled submissive self-conscious lonely sensitive* other \_\_\_\_\_

Have you ever felt people were watching you? Yes \_\_\_\_ No \_\_\_\_  
 Do people's faces ever seem distorted? Yes \_\_\_\_ No \_\_\_\_  
 Do you ever have difficulty distinguishing faces? Yes \_\_\_\_ No \_\_\_\_  
 Do colors ever seem too bright? Yes \_\_\_\_ No \_\_\_\_  
 Are you sometimes unable to judge distance? Yes \_\_\_\_ No \_\_\_\_  
 Have you ever had hallucinations? Yes \_\_\_\_ No \_\_\_\_  
 Is your hearing exceptionally good? Yes \_\_\_\_ No \_\_\_\_  
 Do you have problems sleeping? Yes \_\_\_\_ No \_\_\_\_  
 How many hours of sleep do you average each night? \_\_\_\_\_

What is your main problem? What brings you here today?

What have you done about your problem?

What do you want us/me to do about it?

Is there any other information I/we should know about?