

Personal Data Inventory

Identification Data

Date: _____

1. Name: _____ 2. Phone: _____
3. Address/City/Zip: _____
4. Email: _____
5. Occupation: _____ 6. Business phone: _____
7. Birth Date: _____ 8. Sex: Male Female 9. Age: _____
10. Marital Status: Single Engaged Married Separated Divorced Remarried Widow
11. Education: Elementary High School GED College Graduate Degree: _____
12. Other Training (List type and years): _____
13. Hobbies: _____
14. Referred to us by: _____ Relationship: _____
15. If you were raised by anyone other than your own parents, briefly explain: _____
16. How many siblings do you have? Older brothers: ___ Sisters: ___ Younger brothers: ___ Sisters: ___

Marriage Information:

17. Name of Spouse: _____ Address: _____
Occupation: _____ Phone: _____ Age: _____
Business Phone: _____ Religion: _____ Education: _____
18. Does your spouse know you are coming for counseling? Yes No
19. Is your spouse willing to come to counseling? Yes No Uncertain
20. Have you ever been separated? Yes No When? From: _____ Till: _____
21. Your ages when married: Husband: _____ Wife: _____ Wedding Date: _____
22. How long did you know your spouse before marriage? _____
23. Length of steady dating with spouse: _____ Length of engagement: _____
24. Give brief information about any previous marriages: _____

25. Information about children:

				CURRENTLY		
*(PM)	NAME	BIRTHDATE	SEX	LIVING?	EDUCATION	MARITAL STATUS

*this column if child is by a previous marriage

yes/no

History Information:

26. Have you ever had a severe emotional upset? Yes No

27. Have you ever had any psychotherapy or counseling before? Yes No

If yes, list counselor or therapist and dates:

What was the outcome?

28. Check off any of the following words which best describe you now:

- | | | | | |
|--------------------------------------|---|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> active | <input type="checkbox"/> ambitious | <input type="checkbox"/> self confident | <input type="checkbox"/> persistent | <input type="checkbox"/> anxious |
| <input type="checkbox"/> hardworking | <input type="checkbox"/> impatient | <input type="checkbox"/> impulsive | <input type="checkbox"/> moody | <input type="checkbox"/> often sad |
| <input type="checkbox"/> excitable | <input type="checkbox"/> imaginative | <input type="checkbox"/> calm | <input type="checkbox"/> serious | <input type="checkbox"/> easy going |
| <input type="checkbox"/> shy | <input type="checkbox"/> fearful | <input type="checkbox"/> introvert | <input type="checkbox"/> extrovert | <input type="checkbox"/> likeable |
| <input type="checkbox"/> leader | <input type="checkbox"/> quiet | <input type="checkbox"/> inflexible | <input type="checkbox"/> submissive | <input type="checkbox"/> sensitive |
| <input type="checkbox"/> lonely | <input type="checkbox"/> self-conscious | <input type="checkbox"/> bitter | <input type="checkbox"/> angry | |

29. At any time have you:

Felt people were watching you? Yes No

Had difficulty recognizing faces? Yes No

Been unable to judge distance? Yes No

Had visual hallucinations? Yes No

Had auditory (hearing) hallucinations? Yes No

30. List fears you have:

31. Have you ever been arrested? Yes No Reason:

Health Information

32. Approximately how many hours of sleep do you get each night? _____

33. When do you go to sleep at night? _____ When do you get up? _____

34. Rate your health: Very Good Good Average Declining Other _____

35. Your approximate: Weight _____ Height _____

36. Weight changes recently: Lost _____ Gained _____

37. List all important present and past illnesses, injuries, or handicaps:

38. Date of last medical examination: _____ What was the report? _____

39. Name and address of your physician:

40. Are you presently taking medication? Yes No What _____

41. Have you used drugs for other than medical purposes? Yes No What _____

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

Religious Background

43. Denominational preference: _____

44. What church do you attend? _____ City: _____

45. Who is your pastor _____

46. May we contact your pastor for background information? Yes No

47. What is the number of church services you attend per month? (circle)

0 1 2 3 4 5 6 7 8 9 10 10+

48. Church attended in childhood: _____

49. Have you been baptized? Yes No

50. Religious background of spouse: _____

51. Do you believe in God? Yes No Uncertain

52. Do you pray to God? Yes No Occasionally

53. Have you come to the place in your spiritual life where you can say that you know for certain that if you were to die today you would go to heaven? Yes No Uncertain

54. Suppose you died today and God asked you "Why should I let you into my heaven?" What would you say?

55. Are you saved? Yes No Uncertain

56. How much do you read the Bible? Often Never Occasionally

57. Does your family regularly read the Bible and pray together? Yes No

58. Explain any recent changes in your religious life, if any?

Five Basic Questions

Briefly answer the following questions:

1. What are the issues you are struggling with?

2. What have you done about it?

3. What do you want us to do? (What are your expectations in coming here?)

4. What circumstances led you to seek counsel here at this time?

5. Is there any other information that would we should know?
