



PERSONAL DATA INVENTORY

Identification Data:

Date _____
Name _____ Home Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Employer & Occupation _____ Business Phone (_____) _____
Sex _____ Birth Date _____ Age _____ Height _____ Cell Phone (_____) _____
Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ E-Mail _____
Education (last year completed) _____ (grade) _____ Other training (list type and years) _____

How did you hear about our counseling ministry? Radio Newspaper Mail Friend Other _____

Health Information:

Rate your general health: Very Good Good Average Declining Other _____

Your approximate weight _____ lbs. Weight changes recently: Lost _____ Gained _____

List all important present or past illnesses, injuries or handicaps _____

Date of last medical examination _____ Report _____

Your physician _____ Address _____

City _____ State _____ Zip _____ Doctor's Phone (_____) _____

Are you presently taking medication? Yes No If so, what? _____

Have you ever had a severe emotional upset? Yes No Explain _____

Have you ever been arrested? Yes No

If needed, 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:

Denominational preference _____ Church Membership At _____

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

Church attended in childhood _____ Baptized? Yes No If yes, age _____

Religious background of spouse (if married) _____

Do you consider yourself a religious person? Yes No Uncertain Do you believe in God? Yes No

Do you pray to God? Never Occasionally Often Everyday Many Times Daily

Are you saved? Yes No Not sure what you mean

How much do you read the Bible? Never Occasionally Often Everyday

Do you have regular family devotions? Yes No

Explain recent changes in your religious life, if any _____

Personality Information:

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-natures introvert extrovert likable leader quiet hard-boiled
submissive self-conscious lonely sensitive depressed other _____

Have you ever felt people were watching you? Yes No Do people's faces ever seem distorted? Yes No
Do colors ever seem too bright? Yes No Too dull? Yes No
Are you sometimes unable to judge distance? Yes No Have you ever had hallucinations? Yes No
Are you afraid of being in a car? Yes No Is your hearing exceptionally good? Yes No
Do you have problems sleeping? Yes No

Marriage and Family Information:

Name of spouse _____ Home Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Employer & Occupation _____ Business Phone (_____) _____
Birth Date _____ Age _____ Cell Phone (_____) _____
Education (in yrs) _____ Religion _____ E-Mail _____

Is your spouse willing to come in for counseling? Yes No Uncertain
Have you ever been separated? Yes No If so, when? From _____ to _____
Has either of you ever filed for divorce? Yes No If so, 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:

Name	Age	Sex	Living? Yes/No	Education (In Years)	Marital Status	Child From Previous Marriage
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

If you were reared by anyone other than your own parents, briefly explain: _____

How many older siblings do you have? Brothers _____ Sisters _____
How many younger siblings do you have? Brothers _____ Sisters _____



Briefly Answer The Following Questions

Name: _____ Date: _____

1. What is the main problem, as you see it? What brings you here?

2. What have you done about it?

3. What can we do? What are your expectations in coming here?

4. As you see yourself, what kind of person are you? Describe yourself.

5. Is there any other information we should know?