

The Biblical Counseling Ministry

Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Sex: _____ Referred By: _____

Marital Status: Single: _____ Engaged: _____ Married: _____ Separated: _____
Divorced: _____ Widowed: _____

Education (last year completed): _____

Home Phone: _____ Work Phone: _____

Employer: _____ Position: _____

Years: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ How Long Employed: _____

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 Ed.:
-------	------	------	---------	-----------

Describe relationship to your father: _____

Describe relationship to your mother:

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

Did you live with anyone other than parents: _____

Are your parents living: _____ Do they live locally: _____

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:

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: _____

Church attending: _____ Member: _____

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:

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

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?