

Personal Data Inventory

General Information

Name: _____ Today's Date: _____

Your Gender: Male Female Birth Date: _____ Age: _____

Full Address: _____

Primary Phone: _____

Education (highest level completed): _____

Degrees / Certificates: _____ Other training: _____

Employer (current or last): _____ Position: _____

Years Employed Here: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Marital Status (check all that apply)

- Single Dating Engaged Married Divorced
 Separated Widowed Remarried Living together & unmarried
I consider myself: Heterosexual Bisexual Homosexual Not sure

Health Information

My Health Is: Very Good Good Average Less-than-average Poor

Current health issues: _____

Primary Physician (name & facility): _____

All current medications (prescription and over-the-counter). List name and purpose of each.

_____ (include diet pills, laxatives, birth control pills, cold and allergy medicines, all pain relievers)

Daily caffeine consumption: _____ Average Sleep/Night: _____ hours
(coffee, tea, caffeinated drinks, etc.) Sleep Quality: _____

Recent weight changes: Gained Lost Approximately _____ pounds in about _____ weeks.

Religious Background

▶ What religion do you associate with: _____ Non-religious
Denomination/sect preference, if any: _____

▶ Describe your current involvement: _____

I'm an official member of my religious organization: Y/N Positions I've held: _____

▶ Church or religious center attended during childhood: _____

▶ Previous involvement in any other religious groups: _____

▶ Baptized? (*check all that apply*) Never As an infant After getting saved
 Other time: _____ Baptized by: _____ At age: _____

▶ Father's Religion: _____ Mother's Religion: _____

▶ Describe your own understanding of God: _____

Level of confidence in God: ____ % Do you pray to God? Never Occasionally Often

Are you forgiven by God? Would you go to Heaven if you died? Yes No Not sure

How frequently do you read the Bible? Never Occasionally Often

Bible reading or prayer with your spouse and children? Never Occasionally Often

▶ Do you have a relationship to Jesus Christ? If so, how did this relationship come about?

▶ Please explain any recent changes in your religious life: _____

▶ God's expectations of you currently: _____

▶ Greatest spiritual need at this point: _____

Circle All That Apply

Have you participated in... masonic lodge | scientology | séances | mysticism | satanism
out-of-body experiences or trances | meditation | occult | cult | magic mediums/channelers
ouija board | tarot cards | spells or curses | divination | communication with spirits
witchcraft/wicca | sorcery

Family Information

Name of Father: _____ Living? Y/N Mother: _____ Living? Y/N

Describe parents' involvement in your life: _____

Parents (*circle all that apply*): Never Married Married Separated Divorced Remarried

Your age when parents separated: _____ Your age when parents divorced: _____

Were you were raised by anyone other than your biological parents? If so, please explain...

List your siblings from oldest to youngest, including yourself. Mark step-siblings with an asterisk (*)...

Marriage Information

Name of spouse: _____ Age: _____ Religion: _____

Education: _____ Employer/occupation: _____

Wedding date & state: _____ Age when married: You _____ Your Spouse _____

Length of dating/engagement relationship: _____ Length of marriage: _____

Have you ever been separated? No Yes... Date & Length: _____

Has either of you ever filed for divorce? No Me My Spouse ...Date: _____

Is your spouse willing to come for counseling if asked? Yes No Uncertain

Brief information about any previous marriages that you and your spouse(s) have had...

_____ Total # Marriages: _____

Children (*SC = your stepchild, no biological relation to you / NM = your **biological child** whose other parent you were not married to*)

SC	NM	Name	Age/Gender	Living? [Y/N]	Occupation	Marital Status
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<input type="checkbox"/>	<input type="checkbox"/>	_____				
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<input type="checkbox"/>	<input type="checkbox"/>	_____				
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<input type="checkbox"/>	<input type="checkbox"/>	_____				
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<input type="checkbox"/>	<input type="checkbox"/>	_____				
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Other Pregnancies (*that you fathered or carried*)

of miscarriages: _____ # of abortions: _____

I could have other children that I haven't met...

(*men only*) Yes No

Relative(s) you are closest to:

Personality Information

Circle any of the following words that describe you currently:

Active Ambitious Self-Confident Persistent Nervous Hardworking Impatient
Impulsive Moody Often-Blue Excitable Imaginative Calm Serious Shy
Easy-Going Good-Natured Introvert Likable Leader Quiet
Submissive Self-Conscious Lonely Sensitive Outgoing Other: _____

Have you ever experienced...

- A severe emotional upset, nervous breakdown, or life-changing crisis? Yes No
→ Hallucinations (not chemically-induced)? Visual Auditory None
→ Suicidal ...thoughts? Yes No | ...plans? Yes No | ...attempts? _____ None
of attempts
→ Homicidal thoughts? Yes No Homicidal plans or attempts? Yes No
→ I have been abused: Yes No I have abused another person: Yes No

In the last year, have you suffered the loss of someone who was close to you? Yes No

Your strengths: _____ Your weaknesses: _____

First exposure to pornography (age): _____ Use of pornography in the last 2 months? Yes No

Past/Present Social Memberships: _____ Hobby organizations, gangs, other social groups

Circle any words that indicate issues that you are experiencing:

Anger	Anxiety / Fear	Bitterness	Children	Conflict
Communication	Depression	Finances	Grief	Guilt/Shame
In-Laws	Health	Lifestyle	Lying	Self-Injury
Memories	Emotions	Marriage	Sex/Lust	Sleeping
Addiction/Habits	Eating Issues	Fatigue/Weakness	Abuse/Violence	Major Changes

Do you currently use any nicotine products (cigarettes, pipe, chew, nicotine gum/patches, etc.) ?

No Yes: _____ Length of use: _____

Have you ever used drugs, medication, or other chemicals for non-medical purposes? Yes No

Have you ever had alcohol-related problems or struggled to control drinking? Yes No

Have you struggled with non-chemical¹ addiction(s)? Yes No

¹ Such as gambling, sexual activity, overeating, overworking, shopping, romance, pornography, the Internet, sports or hobbies, cutting/self-mutilation, anorexia or bulimia, TV, codependency, etc.

Other Professional Support

Have you ever been diagnosed with... Bipolar Schizophrenia Depression

Borderline Personality Anxiety Panic Attacks Eating Disorder

Obsessive Compulsive Disorder (OCD) Post Traumatic Stress Disorder (PTSD)

► Are you currently working with any other counselor or therapist? Yes No

► Have you ever participated in counseling or therapy in the past? Yes No

*Please list all past/current counselors, therapists, psychologists, and psychiatrists you have had.
Include any times when you have been admitted to mental health facilities...*

1. **Name & Organization:** _____ **Location:** _____

Approximate Beginning & End Dates: _____ to _____

Initial reason for seeking help: _____

Please list any diagnosis you received and any medication you were prescribed:

What was the outcome of the counseling/therapy? Was it helpful? If not, why not?

2. **Name & Organization:** _____ **Location:** _____

Approximate Beginning & End Dates: _____ to _____

Initial reason for seeking help: _____

Please list any diagnosis you received and any medication you were prescribed:

What was the outcome of the counseling/therapy? Was it helpful? If not, why not?

3. **Name & Organization:** _____ **Location:** _____

Approximate Beginning & End Dates: _____ to _____

Initial reason for seeking help: _____

Please list any diagnosis you received and any medication you were prescribed:

What was the outcome of the counseling/therapy? Was it helpful? If not, why not?

Legal Issues

Have you ever: ...been arrested? Y/N ...been under a restraining order? Y/N ...had a warrant? Y/N

State circumstances & dates: _____

Have you ever been imprisoned? No Yes... Date & Length: _____

Briefly state reason/charge(s): _____

Are you on probation or parole? No Yes... Length: _____

Are you involved in any active legal cases? No Yes... _____

Briefly Answer the Following Questions:

1. What brings you to counseling? Please write a quick summary of your main concerns.

...How long have you had these concerns?

2. What have you already done about these concerns? What have been the results?

3. What do you want us to do? What are your expectations and goals in coming here?

4. Is there any other information that we should know?

5. From whom do you normally receive advice for problems? (check all that apply)

Friend Pastor Relative / Family Neighbor

Counselor / Therapist Other: _____

6. Were you referred here by someone? No Yes:

Name & relationship: _____

7. My involvement in counseling was placed on me as a requirement: No Yes...

If so, please explain: