PERSONAL DATA INVENTORY

IDENTIFICATION DATA:

Today's Date_____
Name:_____ Home Phone_____
Address:_____
Occupation:_____ Business Phone_____
Birth Date:_____ Age:____ Sex:____ Email:_____
Referred here by:_____ Address_____

HEALTH INFORMATION:

Rate your health:(circle)Very good/good/average/declining/other
Your approximate Height_____ Weight:_____lbs.
Recent weight changes: Lost_____lbs. Gained_____lbs.
List all important (present or past) injuries or handicaps:

Date of last Medical Exam:_____Report:_____

Your Physician:_____Address:_____
Have you ever had a severe emotional upset? Yes___No___Explain:

List all prescription and over-the-counter medications (include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, herbals, etc.)

What is your average daily caffeine consumption? Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks.

Do you consume alcoholic beverages?___ If so, how much and how frequently?_____ Do you smoke?___ How much?_____

How many hours of sleep do you average each night?____ What time do you normally: Go to bed?____ Fall asleep?____ Wake up?____
Get up?____ Is sleep restful?____ Explain any recent changes:

Have you used drugs for other than medical purposes? Yes___No___
Which drugs?

Have you ever been arrested? Yes___No___ Explain:

Have you ever had hallucinations? Yes___No___
Are you afraid of being in a car, elevator, airplane? Yes___No___
Is your hearing exceptionally good? Yes___No___
Do you have problems sleeping? Yes___No___

OCCUPATIONAL INFORMATION:

Education completed:_____
Where do you work and what kind of work do you do?

How long have you been at your present employment? _____
Where were your previous places of employment and types of work?

Is your present work fulfilling?_____ Explain:

MARRIAGE AND FAMILY INFORMATION:

Married___Separated___Divorced___Widowed___ How long? _____
Name of Spouse: _____ Occupation:_____
Spouse's Age:_____Education:(yrs.)_____Religion:_____
Is spouse willing to come for counseling? Yes___No___Uncertain___
Have you ever been separated? Yes__No__When?_____How long?_____
Have either of you ever filed for divorce? Yes__No__When?_____
Ages when married: Husband_____Wife_____
How long did you know your spouse before marriage?_____
Describe premarital counseling?_____
Give brief information about any previous marriages:

Information about children:

Name	Age	Sex	Living y/n	Education In yrs.	Marital status	Living with you? y/n	*PM

*Check PM column if child is by previous marriage

If you were raised by anyone other than your parents, explain:

How many older brothers_____sisters_____do you have?
How many younger brothers_____sisters_____do you have?

RELIGIOUS BACKGROUND:

Denominational preference:_____Church:_____
Member:Yes___No___ If yes, how long?____ Pastor:_____
Church Attendance per month (circle): 0 1 2 3 4 5 6 7 8 9 10+
Church Attended in childhood: _____
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? Never___Occasionally___Often___
Are you saved? Yes___No___In process___Not sure what you mean___
How much do you read the Bible? Never___Occasionally___Often___
Do you have regular family devotions? Yes___No___
Have you discussed your problem with your pastor?
Explain recent changes in your religious life, if any:

PERSONAL INFORMATION:

Have you ever had psychotherapy or counseling before? Yes___No___
If yes, list counselor and dates:

Describe the outcome?

CIRCLE ANY OF THE FOLLOWING WORDS WHICH 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 extrovert likeable
leader quiet hardboiled submissive self-conscious lonely
sensitive other:_____

Have you or others noticed any changes in your personality
(anger, mood swings, withdrawl), thinking, memory, work habits?

Have you ever felt people 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 recently suffered any losses (family, someone close,
social, financial, business)?

In case of emergency contact:_____@_____
Parents living?_____Locally?_____
Siblings live locally?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) WHAT IS YOUR MAIN PROBLEM AS YOU SEE IT (what brings you here)?

2) WHAT HAVE YOU DONE ABOUT YOUR PROBLEM?

3) WHAT DO YOU WANT US TO DO ABOUT IT (what are your expectations from counseling)?

4) WHAT ARE YOUR RELATED FEARS?

5) AS YOU SEE YOURSELF, WHAT KIND OF PERSON ARE YOU? (describe yourself)

6) IS THERE ANY OTHER INFORMATION WE SHOULD KNOW?