Personal Data Inventory

Please complete this inventory carefully.

Biblical Counseling Ministries ♦ Christ Fellowship Bible Church ♦ 9321 Litzsinger Road Brentwood MO 63144

Today's date: ________ / /___

Personal Identification

❑ Mr. ❑ Mrs. ❑ Miss ❑ _______ Name ______________________________________

Address ___________________________________ City _________________ Zip_____

Home Phone (________) __________________ Other Phone (_______) ______________

E-mail ____

Birth Date ______/ _____/ _____ Age______ Referred By_________________________

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

Education (last year or degree completed)____

Employer ___________________________ Position _____________________Years ___

In case of an emergency, please contact _________________________ (_____) _________

Name, Relationship Phone Number

Marriage and Family

Spouse____ Birth Date________/_______/___

Age _________Occupation _______________________How Long Employed__________

Home Phone (_______) ____________________ Business Phone (_______) ____________

Date of Marriage _________________________Length of Dating____________________

Give a brief statement of circumstances of meeting and dating ________________________

____

Have either of you been previously married? _________ Who _______________________

Have you ever been separated? _______ Filed for divorce? _______

Information about children

Name	Age	Gender	Education (last year Or degree completed)	Step-Child?
				❑
				❑
				❑
				❑
				❑

Describe relationship to your father ____

____

Describe relationship to your mother ____

____

Number of siblings __________ 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 last medical exam ______ Report ____

Physician's name and address ____

Women only: If you experience any significant symptoms related to your menstrual cycle, please explain____

Current medication(s) and dosage ____

____

Have you ever used drugs for other than medical purposes? _________________________

If yes, please explain: ____

____

Have you ever been arrested? ____

Do you drink alcoholic beverages? ______ How much and how frequently? ___________

____

Do you drink coffee? _______ How much and how frequently? ______________________

Other caffeinated drinks _______ How much and how frequently? __________________

Do you smoke? ______ What? ____________ Frequency ________________________

Have you ever had interpersonal problems on the job? _______ If yes, please explain ____

____

Have you ever had a severe emotional upset? _____ If yes, explain __________________

____

Have you ever seen a psychiatrist or counselor? ______ If yes, 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

Do you believe in God? ______ Do you pray? _______ Would you say you are a Christian, or still in the process of becoming a Christian ____________________Have you been baptized? __

How often do you read the Bible? ❑ Never ❑ Occasionally ❑ Often ❑ Daily

Denominational preference ____

Church attending ____ Member __

How often do you attend church?

❑ Never ❑ Occasionally ❑ Once or twice a month ❑ Weekly ❑ More than once a week

Explain any recent changes in your religious life _________________________________

____

Women Only

Have you had any menstrual difficulties? ________ Do 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, 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	❑ Abortion

BRIEFLY ANSWER THE FOLLOWING QUESTIONS

1. What problem are you having (what brings you here)?

2. What have you done about this problem?

3. What are your expectations from counseling?

4. Is there any other information we should know?

*** PLEASE RETURN THE COMPLETED FORM TO: INFO@CFBCSTL.ORG