BELIEVERS' BIBLICAL COUNSELING CENTER

Personal Data Inventory

Please fill out carefully and completely

Personal Identification:

Name: _____ Birth Date: _____

Address: _____

Phone Number: _____ Best time to contact: _____

Email: _____

Education (highest degree and year received): _____

Employer: _____ Position: _____

Emergency contact person and relationship: _____

Marriage and Family:

Marital status: _____ Length of relationship: _____

Name of Spouse/Significant Other: _____ Age: _____

Occupation: _____ Have you ever separated? _____

If so, how long? _____ Are you currently living together? _____

Have either of you been previously married? _____

Brief statement on condition of relationship: _____

_____

Are they willing to come for counseling? If not, explain: _____

_____

Children:

Name:	Age:	Sex:	Adopted?	Previous Marriage?	Stepchild?

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Briefly describe your relationship to your parents: _____

_____

Are your parents living? _____

Number of siblings: _____ When you were growing up, did you ever live with anyone other than your parents? If so, explain: _____

_____

Spiritual:

Do you believe there is a God? _____ Would you call yourself a Christian? _____

Have you been baptized? _____ Denominational preference: _____

How often do you pray? _____

How often do you read the Bible? _____

What church do you attend? _____

How often do you attend church per month (circle one): 0 1 2 3 4 5 6 7 8 9 10+

Are you a member? _____ How are you involved? _____

Briefly explain any recent changes in your spiritual life: _____

_____

Health:

Describe your overall health: _____

Date of last medical exam: _____ Name of Physician: _____

Do you have any chronic conditions? Briefly explain: _____

_____

List illnesses, injuries, or handicaps: _____

_____

Have you ever used drugs for anything other than medical purposes? _____

If yes, explain: _____

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Have you ever been arrested? _____

If yes, explain: _____

How much of the following do you consume daily?

Alcohol: _____ Coffee or Tea: _____ Soft Drinks: _____ Water: _____

Do you smoke? _____ What? _____ How often? _____

How many hours of sleep do you get a night? _____

Have you ever had a severe emotional upset? _____

If yes, explain: _____

Have you ever seen a psychiatrist or counselor? _____

If yes, explain: _____

Have you noticed any recent changes in your personality, memory, or habits? _____

If yes, explain: _____

Describe your personality using 5 or more words: _____

_____

Current Medications:

Medication:	Dosage:	Medication:	Dosage:

Problems: (circle all that apply)

Anger	Anxiety	Apathy	Bitterness	Children	Communication
Conflicts	Deception	Decision Making	Depression	Drunkenness	Envy
Fear	Finances	Gluttony	Guilt	Health	Homosexuality
Impotence	Loneliness	Lust	Memory	Moodiness	Perfectionism
Rebellion	Sex	Sleep	Spouse Abuse	A Vice	

Other: _____

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Additional Information

1) What is your problem? (What brings you here?) _____
   _____
   _____
   _____

2) What have you tried doing about this problem? _____
   _____
   _____
   _____

3) What are your expectations from biblical counseling? _____
   _____
   _____
   _____

4) Is there any other information we should know? _____
   _____
   _____
   _____