Personal Data Inventory

Counselee Information

Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apt/Unit #

City _____ State/Country _____ Zip Code _____

Phone: _____ ☐ Home ☐ Cell ☐ Work Email: _____

Age: _____ Sex: _____ Referred by: _____

Employer: _____ Years: _____ Weekly Work Hours: _____

Occupation: _____ Business Phone: _____

Education Completed: _____ Degree/Certificate: _____

Other Training: _____

School (if a student): _____ Year: _____

Available Times: Monday Tuesday Wednesday Thursday Friday

Marriage And Family

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Spouse's Name: _____ Age: _____ Email: _____

Phone: _____ ☐ Home ☐ Cell ☐ Work Marriage Date: _____

Address (if different): _____
Street Address Apt/Unit #

City _____ State/Country _____ Zip Code _____

Employer: _____ Years: _____ Weekly Work Hours: _____

Occupation: _____ Business Phone: _____

Education Completed: _____ Degree/Certificate: _____

School (if a student): _____ Year: _____

Length of Time You've Known Spouse: _____ Length of Dating: _____ Length of Engagement: _____

Give a brief statement of circumstances of Meeting/Dating:

Have you and your spouse ever been separated? ☐ **Yes** ☐ **No** If yes, please provide details:

Have you or your spouse ever filed for divorce? ☐ **Yes** ☐ **No** If yes, please provide details:

If previously married, please provide brief information regarding previous marriages.

Is your spouse willing to come in for counseling? ☐ **Yes** ☐ **No** ☐ **Uncertain**

Does your spouse support you coming in for counseling? ☐ **Yes** ☐ **No** ☐ **Uncertain**

What are your parents' religious convictions? _____

Information Regarding Children:

Name:	Age:	Sex:	Living:	Year in Education:	Marital Status:	Step-child?	In Home?

Did you grow up with your parents? ☐ **Yes** ☐ **No** If no, please briefly explain:

Are your parents still married? ☐ **Yes** ☐ **No** Are your parents still living? ☐ **Yes** ☐ **No**

Describe your relationship with your father:

Describe your relationship with your mother:

How many brothers? _____ How many sisters? _____ Sibling Order: _____

Have there been any deaths in your family during the last year? ☐ **Yes** ☐ **No** If yes, who and when:

Personal Information

Have you attended psychotherapy or counseling before? ☐ **Yes** ☐ **No** If yes, please list counselor, dates, and outcome:

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No** If yes, please list what and the frequency:

Do you drink caffeinated beverages? ☐ **Yes** ☐ **No** If yes, please list what and the frequency:

Have you ever used recreational drugs? ☐ **Yes** ☐ **No** If yes, please list what and the frequency:

How many hours a week do you spend looking at screens (TV, Video Games, Social Media, etc.)? Explain.

Hobbies or other significant time commitments?

Have you ever been arrested and/or incarcerated? ☐ **Yes** ☐ **No**

Health Information

Describe your overall health, any chronic conditions, important illnesses, injuries, or handicaps:

Date of last medical exam: _____ ***Report:*** _____

Do you have a family doctor or physician that you see regularly? ☐ **Yes** ☐ **No**

Please list your current medications and dosage:

What are your sleep habits?

Please explain any difficulties you may face uniquely as a man or woman regarding your health:

Religious Information

Church Currently Attending: _____ Denomination: _____

Church Attendance per month: _____ Are you currently a member? ☐ **Yes** ☐ **No**

Church Attended as Child: _____ Are you currently involved in ministry? ☐ **Yes** ☐ **No**

Do you believe in God? ☐ **Yes** ☐ **No** Would you say you are a Christian? ☐ **Yes** ☐ **No** Have you been baptized? ☐ **Yes** ☐ **No**

Do you pray? ☐ **Yes** ☐ **No** How often? _____ Do you read the Bible? ☐ **Yes** ☐ **No** How often? _____

Have you ever been discipled? **Yes** ☐ **No** ☐ If yes, please describe your discipleship experience.

Describe any recent changes in your religious life:

Name the three greatest positive influences on your spiritual life:

1. _____
2. _____
3. _____

Name the three greatest negative influences on your spiritual life:

1. _____
2. _____
3. _____

Personality Dynamics

Please circle or check the personality traits that you believe apply to you.

☐ Active	☐ Imaginative	☐ Easily angered	☐ Impatient	☐ Introvert	☐ Hardworking	☐ Nervous
☐ Ambitious	☐ Calm	☐ Submissive	☐ Impulsive	☐ Extrovert	☐ Good natured	☐ Excitable
☐ Self-confident	☐ Serious	☐ Self-conscious	☐ Moody	☐ Likeable	☐ Shy	☐ Sensitive
☐ Persistent	☐ Easy going	☐ Lonely	☐ Often blue	☐ Leader	☐ Quiet	

Others:

Problem Identification

Please identify any struggles you and/or your family are experiencing in the following chart.
Rate a problem **0** or leave blank for no impact; **1** for mild impact; **2** for moderate impact; or **3** for severe impact.

You	Family		You	Family	
0	0	Abuse / Spousal Abuse	0	0	Intrusive Thoughts
0	0	Abuse in Past	0	0	Judgmental
0	0	Addiction to:	0	0	Lack of Purpose
0	0	Anger	0	0	Laziness / Procrastinating
0	0	Anxiety / Worry	0	0	Leadership
0	0	Apathy	0	0	Lifestyle Change
0	0	Bad Memories	0	0	Loneliness
0	0	Bitterness / Grudges	0	0	Lust
0	0	Busyness / Time Management	0	0	Manipulation
0	0	Caring for Parents	0	0	Marriage
0	0	Chronic Pain	0	0	Miscarriage
0	0	Codependency	0	0	Moodiness / Controlling Emotions
0	0	Communication	0	0	OCD / Compulsions
0	0	Conflict (fights)	0	0	Overwhelmed
0	0	Control	0	0	Panic Attacks
0	0	Debt	0	0	Parenting / Family
0	0	Deception / Lying	0	0	Peer Pressure
0	0	Decision making	0	0	People Pleasing
0	0	Depression / Downcast	0	0	Perfectionism
0	0	Discontentment	0	0	Pornography
0	0	Discouragement	0	0	Pre-marital Sex
0	0	Disorganization	0	0	Pride / Humility
0	0	Divorce Recovery	0	0	Priorities
0	0	Doubting Salvation	0	0	PTSD
0	0	Drunkenness	0	0	Rebellion
0	0	Eating Disorder	0	0	Rejection
0	0	Empty Nesting	0	0	Relationships
0	0	Envy / Jealousy	0	0	Respect
0	0	Fatigue / Weariness	0	0	Same-Sex Attraction / Homosexuality
0	0	Fear	0	0	Self-Control / Disciplined Living
0	0	Financial Management	0	0	Self-Harm
0	0	Gluttony	0	0	Selfishness
0	0	Greed	0	0	Sexual Immorality
0	0	Grief	0	0	Shame
0	0	Guilt	0	0	Sleep
0	0	Hallucinations	0	0	Social Anxiety
0	0	Health / Illness	0	0	Social Media
0	0	Identity	0	0	Spiritual Growth / Sanctification
0	0	Impatience	0	0	Submission
0	0	In-Law Conflict	0	0	Suicidal Thoughts
0	0	Infertility	0	0	Transgenderism / Gender Dysphoria
0	0	Insecurity	0	0	Trauma
0	0	Internet / Online Sins	0	0	Unfulfilled at Work
0	0	Intimacy (Emotional)	0	0	Video Games
0	0	Intimacy (Sexual)	0	0	Weariness

Please describe the problem that led you to seek counseling.

When did the difficulty begin?

What have you done about this difficulty?

Have you spoken about it with your pastor and/or other mature members of your church? If yes, please explain who and what the results were. If no, please explain your concerns about doing so.

What do you hope the outcome is from counseling?

Have you or others noticed any changes in your personality? If yes, please explain.

Have you recently had any significant changes in your relationships, job, or lifestyle? If yes, please explain.

Have you recently lost someone that is close to you? If yes, please explain.

Do you have anything of which you are fearful of? **Yes** ☐ **No** ☐

Is there any other information we should know? **Yes** ☐ **No** ☐ If yes, please provide details.

Pastoral Information

Pastor's Name: _____

Pastor's Primary Phone: _____ Email: _____

Do you give permission to the counselor to consult with your pastor as deemed helpful by counselor?

Signature: _____ Date: _____