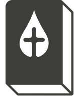

Applied Biblical Counseling

Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: ______________________________ Birth Date: ______________

Address: ________________________________ Zip Code: ___________

Age: _______ Sex: _______ Referred By: ____________________________

Marital Status:

Single: _____ Engaged: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Education (last year completed): ___________________________________

Home Phone: ______________________ Work Phone: __________________

Employer: ________________ Position: _________________ Years: _________

Spiritual

Denominational preference: _______________________________________

Church attending: ____________________________ Member: ___________

Church attendance per month (circle): 0 1 2 3 4 5 6 7 8+

Do you believe in God: _____ Do you pray: _____ Would you say that you are a Christian: _____,

Or still in the process of becoming a Christian: ___________________________

Have you ever been baptized: _____________________________________

How often do you read the Bible: Never: _____ Occasionally: _____ Often: _____ Daily: _____

Explain any recent changes in your religious life: ___________________________

____

Marriage and Family

Spouse: ______________________________ Birth Date: ______________

Age: ______ Occupation: ______________ How Long Employed: ______________

Home Phone: ______________________ Work Phone: ______________________

Date of Marriage: ______________ Length of Dating: ______________________

Give a brief statement of circumstances of meeting and dating: ______________

____

Have either of you been previously married: ____ To Whom: ______________

Have you ever been separated: __________ Filed for divorce: ______________

Information about Children:

Name: Age: Sex: Living: Year Ed.: Step-Child:

____

____

____

____

____

____

____

Describe relationship to your father: ______________________________

____

Describe relationship to your mother: ______________________________

____

Number of sibling(s): _____ 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 of last medical exam: _________ Report: ______________________________

Physician's name and address: ______________________________________

Current medication(s) and dosage: ______________________________________

____

Have you ever-used drugs for anything other than medical purposes: ________________

If yes, please explain: ____

____

Have you ever been arrested: ______________________________________

Do you drink alcoholic beverages: _________ If so, how frequently and how much: __________

____

Do you drink coffee: ________ How much: _________ Other caffeine drinks: ______________

______________________ How much: ______________________________

Do you smoke: ____________What: ______________ Frequency: ______________________

Have you ever had interpersonal problems on the job: ____________________________

____

Have you ever had a severe emotional upset: _____ If yes, please explain: ______________

____

Have you ever seen a psychiatrist or counselor: __________ If yes, please explain: __________

____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records: ______________________________

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	_______ Other

Briefly Answer The Following Questions

1. What is your problem (what brings you here)?

2. What have you done about the problem?

3. What are your expectations from counseling?

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

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