

The Biblical Counseling Ministry Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Gender: _____ Referred By: _____

Marital Status (circle): Single Engaged Married Separated Divorced Widowed

Education (last year completed): _____

Home Phone: _____ Other Phone: _____

Employer: _____ Position: _____

Years: _____ Attend School: _____ Weekly Work/School hours: _____

Hobbies: _____

Other significant time/financial commitments: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ How Long Employed: _____

Home Phone: _____ Other 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: _____ Gender: _____ Living: _____ Year Ed.: _____ Step-Child: _____

Describe relationship to your father: _____

Describe relationship to your mother: _____

Number of sibling(s): _____ Your sibling order: _____

Do you or have you lived with anyone other than parents: _____

Parents still married: _____ Parents living: _____ Parents live locally: _____

Parent's religious convictions, were/are they believers: _____

Health

Describe your overall health: _____

Describe any chronic conditions, important illnesses, injuries, or handicaps: _____

Date of last medical exam: _____ Report: _____

Do you have a family doctor or physician you see regularly? _____

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: _____

Use Tobacco: _____ What: _____ Frequency: _____

Describe your normal sleeping schedule: _____

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 (if needed): _____

Spiritual

Denominational preference: _____

Church attending: _____ Member: _____

Pastor's Name: _____ Pastor's Phone Number: _____

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: _____ Are you involved in ministry: _____

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

Have you ever been discipled? If yes, please describe: _____

Explain any recent changes in your religious life: _____

What are the three biggest positive influences on your spiritual life: _____

What are the three biggest negative influences on your spiritual life: _____

Have you shared the problems for which you are seeking counseling with your pastor and/or other mature members of your church? If yes, please write down their names. If no, please describe any concerns you have about doing so: _____

Women Only

Have you had any menstrual difficulties: _____ If 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, please explain: _____

Problem Checklist: Please rate how these items impact your life

(blank) = no significant impact; 1 = mild impact; 2 = moderate impact; 3 = severe impact

_____ Anger	_____ Discouraged/Downcast	_____ Memory
_____ Anxiety	_____ Drunkenness	_____ Moodiness
_____ Apathy	_____ Envy	_____ Overwhelmed
_____ Appetite	_____ Fear	_____ Perfectionism
_____ Bitterness	_____ Finances	_____ Pornography
_____ Change in lifestyle	_____ Gluttony	_____ Procrastination
_____ Children	_____ Guilt	_____ Rebellion
_____ Communication	_____ Health	_____ Sexual Immorality
_____ Conflict (fights)	_____ Homosexuality	_____ Sex(in marriage)
_____ Control	_____ Impotence	_____ Sleep
_____ Deception	_____ In-laws	_____ Spouse Abuse
_____ Decision Making	_____ Laziness	_____ Time Usage
_____ Depression	_____ Loneliness	_____ Weary
_____ Disciplined Living	_____ Lust	_____ Other
_____ Disorganization	_____ Marriage	

Briefly Answer The Following Questions

1. Why have you sought counseling? What difficulties are you facing?
2. What have you done about the difficulties?
3. What are your expectations from counseling?
4. Is there any other information that we should know?