BIBLICAL COUNSELING

Applying the Counsel of God's Word to the Issues of Life

12109 Old Olean Rd (Box 385), Yorkshire, NY 14173 716-353-3686

Personal Data Inventory

(Please completely fill out this form and submit it prior to your first session.)

Identification Data

Name:_____ Date:_____

Address:_____ (street, city, & zip)

Sex:_____ Date of Birth:_____ Age:_____

Home phone:_____ Cell phone:_____ text? Yes / No

Education (last year completed): _____

Other training:_____

Referred here by:_____

Personal History

Parents: Name Age(if living) Occupation Marital Status

Father_____

Mother_____

Guardian:_____ (if applicable)

Relation to you:_____ Reason for Guardianship _____ Date_____ to _____

Which applicable, which parent raised you?_____

Did you live with anyone other than parents?_____

Siblings: Name Age(if living) Occupation Marital Status

_____

_____

_____

_____

_____

More than five? Yes____ No_____

Would you rate your home-life growing up as well adjusted_____, average_____, or poor_____.

Has there been a death of a close member of your family?_____

If so, what relationship were they to you and when did they die?

_____

Indicate which might have applied during your childhood and/or adolescence:

School problems:_____ Family Problems:_____ Medical Problems:_____

Drug/Alcohol problems:_____ Social problems:_____ Legal problems:_____

Please explain:_____

Describe relationship with your father _____

Describe relationship with your mother _____

Marital History

Marital status: Single Engaged Married Remarried Separated Divorced Widowed

Your present marriage (if applicable):

Spouses name:_____ Age_____ Occupation:_____
Spouses religious background:_____ Education:_____
Date of marriage _____ Have you ever been separated from your present spouse?_____
If yes, please specify when: 1)_____to_____ 2)_____to_____

Children: Name Relationship (son, step-son, etc) Living at Home Age Marital status Occupation

_____
_____
_____
_____

Date of marriage _____ _____ Length of dating _____
Give a brief statement of circumstances of meeting and dating _____
_____

Your previous marriages (if applicable)

Date	Children from this marriage
_____ to _____	_____
_____ to _____	_____
_____ to _____	_____
_____ to _____	_____

Spouse's previous marriages (if applicable)

Date	Children from this marriage
_____ to _____	_____
_____ to _____	_____
_____ to _____	_____
_____ to _____	_____

Health History

Do you have any current health problems?_____ If 'yes', please specify?_____
_____
Do you have any chronic conditions?_____ What?_____
Have you had any of the following physical problems? Please check.

Heart problems_____	Bulimia_____	Menstrual irregularities_____
Liver problems_____	Anorexia_____	Kidney problems_____
Visual problems_____	Hallucinations_____	Head injury/concussion_____
Sensory distortion_____	Change in sex drive_____	Stroke_____
Weakness_____	Seizures_____	Fatigue_____
Problems walking_____	Brain tumor_____	Heat/cold sensitivity_____
Unusual hair loss_____	Multiple Sclerosis_____	Rashes_____
Parkinson's disease_____	Bowel/bladder_____	Memory problems_____
Blackouts_____	Nausea/vomiting_____	Episodic distortions_____
Amnesia_____	Weight change_____	Tremors_____
Impotence_____	Personality change_____	Thyroid dysfunction_____
Physical change_____	Déjà vu_____	Diabetes_____
Constant hunger_____	Food cravings_____	Hypoglycemia_____
Changes in consciousness_____	Lung problems_____	Fever_____
Headaches_____	Allergies_____	Pneumonia_____
Dizziness_____	Cancer_____	Stiff neck_____
Speech problems_____	High Blood Pressure_____	Incoordination_____

Date of last medical exam_____

Physician's name and address_____

List previous surgeries (those which required anesthesia):

List all prescription and over-the-counter medications: Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin:

Have you ever been prescribed anti-depressants?

What is your average daily caffeine consumption? Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks:

How many hours of sleep do you average each night? Have there been any recent changes? Is this sleep restful?

Have you or others noticed any changes in your personality (anger, mood swings, withdrawal) thinking and memory, or work habits?

Are you bothered by nervousness of any kind (trouble sleeping, upset stomach, jittery feelings, etc.)? _____

Have you ever had a severe emotional upset? Yes_____ No_____
Explain:_____

Have you ever been arrested? Yes_____ No_____ Explain:_____
_____

Have you ever received counseling?_____ Presently?_____

If 'yes', please specify when and with whom:_____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or medical reports? Yes_____ No_____

Women Only

Have you had any menstrual difficulties _____
Do you experience tension, tendency to cry, or other symptoms prior to your cycle; please explain
_____
_____
Is your husband willing to come to counseling _____
Is he in favor of your coming _____ If no, explain _____
_____

Occupational History

What jobs have you held in the past?_____
_____

Employer _____What is your job title?_____

How long have you been involved in this job? _____ Present annual income:_____

Does your present work satisfy you? If not, please explain. _____
_____

Religious Background

Church presently attending (Name & address):_____
_____Phone:_____

Member? Yes No

Pastor:_____ Permission to consult with pastor: Yes No

Do you believe in God? Yes_____ No_____ Uncertain_____

Do you consider yourself born again? Yes_____ No_____ Uncertain_____ Not sure what you mean_____

How often do you attend church?_____Are you actively involved? _____

In what ways do you serve in your local church?_____

Do you read the Bible: daily_____ occasionally_____ never _____

Do you pray: daily_____ occasionally_____ never_____

Does your family have family devotions: daily _____ occasionally_____ never_____

If you were to die and stand before God and He asked you why He should permit you to enter Heaven, how might you respond?_____

How would you describe your relationship with God?_____

About yourself

CIRCLE any of the following words which best describe you *now*: active ambitious self-confident persistent nervous hardworking impatient impulsive moody kindly often-blue excitable imaginative calm serious easy-going shy good-natured introvert extrovert likeable leader quiet hard-boiled submissive spiritual self-conscious lonely sensitive other _____.

PROBLEM CHECK LIST ____ Anger _____ Envy _____ Appetite ____ Anxiety ____ Fear ____ Memory _____ Apathy _____ Gluttony ____ Moodiness _____ Bitterness ____ Guilt _____ Rebellion ____ Change in lifestyle _____ Health _____ Sex _____ Children _____ Homosexuality ____ Sleep ____ Depression _____ Impotence _____ Wife abuse ____ Deception ____ In-laws _____ A vice

Please take your time in answering the following questions:

State in your own words the nature of the main problem(s) that bring you for Biblical counseling:

When did your problems begin? Please specify a date if possible.

Please describe any significant events occurring at that time:

What have you done to try to resolve your problem(s):

What would you like us to do for you? What kind of help do you expect?

Is there any other information we should know?