

## Personal Data Inventory

### **Identification Data:**

1. Name \_\_\_\_\_ 2. Phone \_\_\_\_\_ 3. Date \_\_\_\_\_

4. Address/City/Zip \_\_\_\_\_

5. Occupation: \_\_\_\_\_ 6. Business phone: \_\_\_\_\_

7. Birth Date: \_\_\_\_\_ 8. Sex:  Male  Female 9. Age: \_\_\_\_\_

10. Marital Status:  Single  Engaged  Married  Separated  Divorced  Remarried  Widow

11. Education:  Elementary  High School  GED  College  Graduate  Degree: \_\_\_\_\_

12. Other Training (List type and years): \_\_\_\_\_

\_\_\_\_\_

13. Hobbies: \_\_\_\_\_

14. Referred to us by: \_\_\_\_\_ Relationship: \_\_\_\_\_

15. If you were raised by anyone other than your own parents, briefly explain: \_\_\_\_\_

\_\_\_\_\_

16. How many siblings do you have? Older brothers: \_\_\_ Sisters: \_\_\_ Younger brothers: \_\_\_  
Sisters: \_\_\_

### **Marriage Information:**

17. Name of Spouse: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_ Religion: \_\_\_\_\_ Education: \_\_\_\_\_

\_\_\_\_\_

18. Does your spouse know you are coming for counseling?  Yes  No

19. Is your spouse willing to come to counseling?  Yes  No  Uncertain

20. Have you ever been separated?  Yes  No When? From: \_\_\_\_\_ Till: \_\_\_\_\_

21. Your ages when married: Husband: \_\_\_\_\_ Wife: \_\_\_\_\_ Wedding Date: \_\_\_\_\_

22. How long did you know your spouse before marriage? \_\_\_\_\_

23. Length of steady dating with spouse: \_\_\_\_\_ Length of engagement: \_\_\_\_\_

24. Give brief information about any previous marriages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Information about children:

*(PM) STATUS	NAME	BIRTHDATE	SEX	LIVING ? yes/no	EDUCATION	MARITAL
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_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

\*Check this column if child is by previous marriage

**History Information:**

26. Have you ever had a severe emotional upset?  Yes  No

27. Have you ever had any psychotherapy or counseling before?  Yes  No

If yes, list counselor or therapist and dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was the outcome?

\_\_\_\_\_  
\_\_\_\_\_

28. Check off any of the following words which best describe you now:

- |                                      |   |   |                                     |                               |
|--------------------------------------|---|---|-------------------------------------|-------------------------------|
| <input type="checkbox"/> active      | <input type="checkbox"/> ambitious      | <input type="checkbox"/> self confident | <input type="checkbox"/> persistent | <input type="checkbox"/>      |
| anxious                              |   |   |                                     |                               |
| <input type="checkbox"/> hardworking | <input type="checkbox"/> impatient      | <input type="checkbox"/> impulsive      | <input type="checkbox"/> moody      | <input type="checkbox"/>      |
| often sad                            |   |   |                                     |                               |
| <input type="checkbox"/> excitable   | <input type="checkbox"/> imaginative    | <input type="checkbox"/> calm           | <input type="checkbox"/> serious    | <input type="checkbox"/> easy |
| going                                |   |   |                                     |                               |
| <input type="checkbox"/> shy         | <input type="checkbox"/> fearful        | <input type="checkbox"/> introvert      | <input type="checkbox"/> extrovert  | <input type="checkbox"/>      |
| likeable                             |   |   |                                     |                               |
| <input type="checkbox"/> leader      | <input type="checkbox"/> quiet          | <input type="checkbox"/> inflexible     | <input type="checkbox"/> submissive | <input type="checkbox"/>      |
| sensitive                            |   |   |                                     |                               |
| <input type="checkbox"/> lonely      | <input type="checkbox"/> self-conscious | <input type="checkbox"/> bitter         | <input type="checkbox"/> angry      |                               |

29. At any time have you:

- Felt people were watching you?       Yes       No
- Had difficulty recognizing faces?       Yes       No
- Been unable to judge distance?       Yes       No
- Had visual hallucinations?       Yes       No
- Had auditory (hearing) hallucinations?       Yes       No

30. List fears you have:

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31. Have you ever been arrested?       Yes       No      Reason:

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**Health Information**

32. Approximately how many hours of sleep do you get each night? \_\_\_\_\_

33. When do you go to sleep at night? \_\_\_\_\_      When do you get up?

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34. Rate your health:  Very Good     Good     Average     Declining     Other

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35. Your approximate: Weight \_\_\_\_\_      Height \_\_\_\_\_

36. Weight changes recently:    Lost \_\_\_\_\_      Gained \_\_\_\_\_

37. List all important present and past illnesses, injuries, or handicaps:

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38. Date of last medical examination: \_\_\_\_\_ What was the report?  
\_\_\_\_\_

39. Name and address of your physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

40. Are you presently taking medication?  Yes  No What  
\_\_\_\_\_

41. Have you used drugs for other than medical purposes?  Yes  No What  
\_\_\_\_\_

42. Are you willing to sign a release of information form so that your counselor may write for social,  
psychiatric, or medical reports?  Yes  No

**Religious Background**

43. Denominational preference: \_\_\_\_\_

44. What church do you attend? \_\_\_\_\_ City:  
\_\_\_\_\_

45. Who is your pastor? \_\_\_\_\_

46. May we contact your pastor for background information?  Yes  No

47. What is the number of church services you attend per month? (circle)

0    1    2    3    4    5    6    7    8    9    10    10+

48. Church attended in childhood: \_\_\_\_\_

49. Have you been baptized?  Yes  No

50. Religious background of spouse: \_\_\_\_\_

51. Do you believe in God?  Yes  No  Uncertain

52. Do you pray to God?  Yes  No  Occasionally

53. Have you come to the place in your spiritual life where you can say that you know for certain that if

you were to die today you would go to heaven?  Yes  No  Uncertain

54. Suppose you died today and God asked you "Why should I let you into my heaven?" What would

you say?  
\_\_\_\_\_  
\_\_\_\_\_

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55. Are you saved?     Yes     No     Uncertain

56. How much do you read the Bible?     Often     Never     Occasionally

57. Does your family regularly read the Bible and pray together?  Yes     No

58. Explain any recent changes in your religious life, if any?

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**Five Basic Questions**

Briefly answer the following questions:

1. What is your problem?

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2. What have you done about it?

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3. What do you want us to do? (What are your expectations in coming here?)

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4. What brings you here at this time?

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5. Is there any other information we should know?

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