

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

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|---------------------------|----------------------------|-------------------------|
| _____ 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 | |

