GRACE
COMMUNITY CHURCH

COUNSELING MINISTRY
PERSONAL DATA INVENTORY

Please print neatly in ink, or type.

PERSONAL IDENTIFICATION

NAME: _____ BIRTHDATE: _____
FIRST MIDDLE LAST *MONTH/DATE/YEAR*

ADDRESS: _____
STREET CITY STATE ZIP

HOME #: _____ WORK #: _____ EMAIL: _____

AGE: _____ SEX: _____ REFERRED BY: _____

MARRITAL STATUS:

☐ SINGLE ☐ ENGAGED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EDUCATION (LAST YEAR COMPLETED): _____

EMPLOYER: _____ POSITION: _____ YEARS: _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____
NAME

_____
RELATIONSHIP *PHONE #*

MARRIAGE & FAMILY

SPOUSE: _____ BIRTHDATE: _____
MONTH/DATE/YEAR

AGE: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____

HOME #: _____ WORK #: _____ EMAIL: _____

DATE OF MARRIAGE: _____ LENGTH OF DATING: _____

GIVE A BRIEF STATEMENT OF CIRCUMSTANCES OF MEETING AND DATING: _____

_____

_____

HAVE EITHER OF YOU BEEN PREVIOUSLY MARRIED? _____ WHO? _____

HAVE YOU EVER BEEN SEPARATED? _____ FILED FOR DIVORCE? _____

MARRIAGE & FAMILY

NAME	AGE	LIVING	YEAR EDU	STEP-CHILD

DESCRIBE RELATIONSHIP TO YOUR FATHER: _____

DESCRIBE RELATIONSHIP TO YOUR MOTHER: _____

OF SIBLINGS: _____ DID YOU LIVE WITH ANYONE OTHER THAN PARENTS? _____

ARE PARENTS LIVING? _____ DO THEY LIVE LOCALLY? _____

HEALTH

DESCRIBE YOUR HEALTH: _____

DO YOU HAVE ANY CHRONIC CONDITIONS? IF SO, WHAT? _____

LIST IMPORTANT ILLNESSES AND INJURIES OR HANDICAPS: _____

_____

DATE OF LAST MEDICAL EXAM: _____ REPORT: _____

PHYSICIAN'S NAME & ADDRESS: _____

CURRENT MEDICATION(S) AND DOSAGE: _____

_____

HAVE YOU EVER USED DRUGS FOR OTHER THAN MEDICAL PURPOSES? IF YES, PLEASE EXPLAIN:

_____

HAVE YOU EVER BEEN ARRESTED? _____ REASON: _____

DO YOU DRINK ALCOHOLIC BEVERAGES? IF SO, HOW FREQUENTLY AND HOW MUCH? _____

_____

DO YOU DRINK COFFEE? IF SO, HOW MUCH? _____

OTHER CAFFEINE DRINKS? HOW MUCH? _____

DO YOU SMOKE? IF SO, WHAT AND HOW FREQUENTLY? _____

HAVE YOU EVER HAD INTERPERSONAL PROBLEMS ON THE JOB? _____

HAVE YOU EVER HAD A SEVERE EMOTIONAL UPSET? IF YES, EXPLAIN: _____

_____

HAVE YOU EVER SEEN A PSYCHIATRIST OR COUNSELOR? IF YES, EXPLAIN: _____

_____

_____

_____

ARE YOU WILLING TO SIGN A RELEASE OF INFORMATION FORM SO THAT YOUR COUNSELOR MAY WRITE FOR SOCIAL, PSYCHIATRIC, OR OTHER MEDICAL RECORDS? _____

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 YOU ARE A CHRISTIAN? _____

OR STILL IN THE PROCESS OF BECOMING A CHRISTIAN? _____

HAVE YOU BEEN BAPTIZED? _____

HOW OFTEN DO YOU READ THE BIBLE? ☐ NEVER ☐ OCCASSIONALLY ☐ OFTEN ☐ DAILY

EXPLAIN ANY RECENT CHANGES IN YOUR RELIGIOUS LIFE: _____

_____

WOMEN ONLY

HAVE YOU HAD ANY MENSTRUAL DIFFICULTIES? _____ DO 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, EXPLAIN: _____

PROBLEM CHECK LIST

- [ ] ANGER
- [ ] ANXIETY
- [ ] APATHY
- [ ] APPETITE
- [ ] BITTERNESS
- [ ] CHANGE IN LIFESTYLE
- [ ] CHILDREN
- [ ] COMMUNICATION
- [ ] CONFLICT (FIGHTS)
- [ ] DECEPTION
- [ ] DECISION MAKING
- [ ] DEPRESSION
- [ ] DRUNKENESS
- [ ] ENVY
- [ ] FEAR
- [ ] FINANCES
- [ ] GLUTTONY
- [ ] GUILT
- [ ] HEALTH
- [ ] HOMOSEXUALITY
- [ ] IMPOTENCE
- [ ] IN-LAWS
- [ ] LONELINESS
- [ ] LUST
- [ ] MEMORY
- [ ] MOODINESS
- [ ] PERFECTIONISM
- [ ] REBELLION
- [ ] SEX
- [ ] SLEEP
- [ ] WIFE ABUSE
- [ ] A VICE
- [ ] OTHER

BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

[1] WHAT IS YOUR PROBLEM (WHAT BRINGS YOU HERE)?

[2] WHAT HAVE YOU DONE ABOUT THIS PROBLEM?

[3] WHAT ARE YOUR EXPECTATIONS FROM COUNSELING?

[4] IS THERE ANY OTHER INFORMATION WE SHOULD KNOW?