Personal Data Inventory

Please complete this inventory carefully.

Discipleship Counseling Ministries ♦ 970-330-1340 ♦ 6400 W. 20th St., Greeley, Colorado 80634

Today's date: ____/____/____

Personal Identification

☐ Mr. ☐ Mrs. ☐ Miss Name _____

Address _____ City _____ ZIP _____

Home phone (_____) _____ Other phone (_____) _____

E-mail _____

Birth date ____/____/_____ Age _____ Referred by _____

Marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Education (last year or degree completed) _____

Employer _____ Position _____ Years _____

In case of an emergency, please contact: _____ (____) _____
Name, Relationship Phone number

Marriage and Family

Spouse _____ Birth date ____/____/____ Age _____

Employer _____ Position _____ Years _____

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? _____

Information about children:

Name	Age	Gender	Education (last year or degree completed)	Step-child?
				☐
				☐
				☐
				☐
				☐

Describe relationship to your father _____

_____

Describe relationship to your mother _____

_____

Number of siblings _____ Your sibling order _____

Did you live with anyone other than parents?_____

_____

Are your parents living? _____ Where do they live? _____

If married, is your spouse willing to come for counseling? _____

Is he/she in favor of your coming? _____ If no, explain _____

_____

Legal

Have you ever been arrested? _____ If yes, please explain _____

_____

Have you ever been the subject or complainant in a protection/restraining order? _____ If yes, please explain _____

Are you currently a party in any civil or criminal proceedings? _____If so, please explain

_____

Health

Describe your health _____

Do you have any chronic conditions? _____ Explain _____

List important illnesses and injuries or handicaps: _____

_____

Date of last medical exam _____ Report _____

Physician's name and address _____

Women only: If you experience any significant symptoms related to your menstrual cycle, please explain ____

_____

Current medication(s) and dosage _____

_____

Have you ever used drugs for other than medical purposes? _____

If yes, explain _____

Do you drink alcoholic beverages? _____ How much and how frequently? _____

Do you drink coffee? _____ How much and how frequently? _____

Other caffeinated drinks? _____ How much and how frequently? _____

Do you smoke? _____ What? _____ Frequency _____

Have you ever had interpersonal problems on the job? _____ If yes, explain _____

_____

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

Do you believe in God? _____ Do you pray? _____ Would you say you are a Christian? _____

Or in the process of becoming a Christian? _____ Have you been baptized? _____

How often do you read the Bible? ☐ Never ☐ Occasionally ☐ Often ☐ Daily

Denominational preference _____

Church attending _____

How often do you attend church?

☐ Never ☐ Occasionally ☐ Once or twice a month ☐ Weekly ☐ More than once a week

How are you involved within the church? _____

Explain any recent changes in your spiritual life_____

_____

Problem Check List

☐ Anger	☐ Depression	☐ Loneliness
☐ Anxiety	☐ Drunkenness	☐ Lust
☐ Apathy	☐ Envy	☐ Memory
☐ Appetite	☐ Fear	☐ Moodiness
☐ Bitterness	☐ Finances	☐ Perfectionism
☐ Changes in lifestyle	☐ Gluttony	☐ Rebellion
☐ Children	☐ Guilt	☐ Sex
☐ Communication	☐ Health	☐ Sleep
☐ Conflicts (fights)	☐ Homosexuality	☐ Wife abuse
☐ Deception	☐ Impotence	☐ A vice
☐ Decision making	☐ In-laws	☐ Other _____

Please answer the following questions

1. What problem are you having (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? _____