



LEROY COMMUNITY CHAPEL

12920 Painesville Warren Rd., Leroy, OH 44077
(440) 254-4747; Fax (440) 254-3159
www.leroychapel.com

Biblical Counseling Inventory

Full Name: _____ Date: ___/___/___

Address: _____ City: _____ Zip Code: _____

Email: _____ DOB: ___/___/___

Home Phone: _____ Occupation: _____

Cell Phone: _____ Are you currently employed? YES NO

Business Phone: _____

Last education completed:

GED High School Some college College Graduate/Masters work

Current Marital Status:

Single Married Separated Divorced Widowed

Referred here by: _____ Phone/Email: _____

How do you know this person? _____

Please mark available times to meet with counselor:

Morning Afternoon Evening
 Monday Tuesday Wednesday Thursday Friday Saturday

Marriage & Family Information

Name of Spouse: _____ Spouse's DOB: ___/___/___

Is his/her address same as above? YES NO

If not: _____

Spouse's occupation: _____ Anniversary: ___/___/___

Ages when married: _____ HUSBAND _____ WIFE

Is your spouse willing to come in for counseling? YES NO

Has your spouse ever been divorced? YES NO

If yes, please explain: _____

Have you been divorced/separated? YES NO

If yes, please explain: _____

Child's Name	Age	Gender	Marital Status

**please mark children from previous marriages/relationships*

Religious Background

Church and denomination attended in childhood: _____

Do you have a denominational preference? _____

How long have you attended Leroy Community Chapel? _____ Leroy Grand River

What ministries are you currently involved in at LCC? _____

Church attendance per month (*circle one*) 0 1 2 3 4 5 6 7 8+

Are you a member of LCC? YES NO

Is your spouse a member of LCC? YES NO

Have you been baptized? YES NO

Does your spouse attend LCC? YES NO

If no, does he/she attend elsewhere? YES NO

Would you describe yourself as a believer? YES NO

What is your basis for answering this question as you did? _____

What changes took place in your life after becoming a believer? _____

Please write out what you believe the gospel is: _____

Do you read the Bible? NEVER OCCASIONALLY OFTEN

Do you pray? NEVER OCCASIONALLY OFTEN

Do you have family devotions? NEVER OCCASIONALLY OFTEN

Do you pray with your spouse? NEVER OCCASIONALLY OFTEN

Do you pray with your children? NEVER OCCASIONALLY OFTEN

Give a brief overview of what your personal devotions looks like: _____

Please explain any recent changes in your spiritual life: _____

Medical & Health Information

Have you received Biblical Counseling at LCC before? YES NO

If so, who was your counselor? _____

Have you received counseling or therapy outside of LCC? YES NO

Please list below.

Counselor/Psychologist/ Psychiatrist	Duration	Medication prescribed?	Diagnosis/ Outcome

Please list 6 words to describe your personality:

Height: _____ Weight: _____ Recent weight change? _____

Average number of hours of sleep per night? _____

Each night, at what time do you: go to bed _____ fall asleep _____ wake up _____

Describe any changes in your sleep patterns _____

Health	VERY GOOD	GOOD	AVERAGE	DECLINING
Hearing	VERY GOOD	GOOD	AVERAGE	DECLINING
Sight	VERY GOOD	GOOD	AVERAGE	DECLINING
Appetite	VERY GOOD	GOOD	AVERAGE	DECLINING
Energy	VERY GOOD	GOOD	AVERAGE	DECLINING

Are you presently taking any medication? YES NO

Medication	Dosage	Side-Effects	How long have you been taking this?

Physician's Name: _____ Phone Number: _____

Date of last medical exam: _____

Have you ever used drugs for other than medical purposes? YES NO

If yes, please explain: _____

Do you drink alcoholic beverages? YES NO How often? _____

Do you smoke? YES NO How much? _____

Would you be willing to release medical and previous counseling information to your counselor in the event that it is necessary? YES NO

Did you read the counseling cover letter? YES NO

Did you read the Biblical Discipleship & Hold Harmless Agreement? YES NO

