

Personal Data Inventory

Trinity Baptist Church Counseling Ministry

Please complete this inventory carefully and thoroughly, and mail to:

Trinity Baptist Church Counseling
3714 Shane Road
Shreveport, LA 71129

Personal Information

Name _____ Today's date ___/___/_____

Address _____ City _____ State _____ Zip _____

Age _____ Sex _____ Height _____ Referred for Counseling by _____

Marital Status (mark all that apply):

Never Married Single Dating Engaged Now Married / How Many Years _____

Now Separated / How Many Months _____ Divorced / How many Times _____ Widowed

Home Phone (____) _____ Work Phone (____) _____ Mobile (____) _____

Email Address _____ Education (Last Level Completed _____

Other Training (List Type and Years) _____

Occupation _____ Employer _____ Position _____ Yrs. _____

In case of an emergency, contact: Name _____ Ph. # (____) _____

Marriage and Family

Information about spouse (If never married check here: and omit this section)

Spouse's Name _____ Spouse's Birth Date ___/___/_____

Spouse's Address _____ City _____ State _____ Zip _____

Spouse's Home Phone (____) _____ Spouse's Work Phone (____) _____

Spouse's Mobile (____) _____ Spouse's Email _____

Spouse's Education (last level completed _____ Spouse's Occupation _____

Spouse's Religious Background _____

Your ages when married: You _____ Spouse _____ Date of Marriage ___/___/_____

Length of Steady Dating _____ Length of Engagement _____

Has your spouse previously been married? Yes No Number of Times _____

Have you and your spouse ever been separated? Yes No When? From _____ To _____

Is your spouse willing to come to counseling? _____

Information on Children

Name	Age	Sex (M/F)	Education (Yrs.)	Step-Child?	Married Y/N	By Previous Marriage?	Living? Y/N

Information about Parents

If you were raised by anyone other than your own parents, briefly explain _____

Is your father still living? Yes No Does he live nearby? _____ Where? _____

Father's Religious Affiliation _____ Father's Occupation _____

Describe your relationship with father _____

Is your mother still living? Yes No Does she live nearby? _____ Where? _____

Mother's Religious Affiliation _____ Mother's Occupation _____

Describe your relationship with mother _____

Have your parent divorced? _____

Rate your parent's marriage Unhappy Average Happy Very Happy

Information about Your Siblings

Number of older brother _____ older sisters _____ younger brothers _____ younger sisters _____

Rate your childhood: Unhappy Average Happy Very Happy

Have there been any deaths in your family during the last year? _____

Legal

If you have talked with an attorney about your situation, or intend to, please provide:

Attorney's Name _____ Firm _____

Address _____ Phone (_____) _____

Has legal action been filed or is one likely to be filed in this situation? _____

If you have received counsel from anyone else regarding your situation, please list their name(s) and their relationship to you. _____

Health History

Rate your health Very Good Good Average Declining Other _____

Do you have any chronic conditions? Yes No If yes, explain: _____

List significant illnesses, injuries, or handicaps _____

Your approximate weight _____ lbs. Weight changes recently? Loss _____ Gained _____

Date of last medical exam _____ Results of examination _____

Physician's Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Are you currently taking any prescription or over-the-counter medications? Yes No

If yes, please explain _____

Have you ever been arrested? Yes No If yes, please explain circumstances _____

Do you drink alcoholic beverages? Yes No If yes, how frequently and how much? _____

Do you drink coffee? Yes No How frequently and how much? _____

Other caffeinated drinks? Yes No How frequently and how much? _____

Do you use tobacco? Yes No What kind? _____ Frequently? _____

Have you ever had interpersonal problems on the job? Yes No If yes, please explain _____

Have you ever had a severe emotional upset? Yes No If yes, please explain _____

Have you ever seen a psychiatrist or counselor? Yes No If yes, please explain _____

List counselor/therapist and dates _____

What was the outcome? _____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric or

Other medical records? Yes No

Have you ever felt people were watching you? Yes No

Do people's faces ever seem to be distorted? Yes No

Do colors sometimes seem.....? Too bright? Too Dull?

Are you sometimes unable to judge distance? Yes No

Have you ever had hallucinations? Yes_____ No_____

Is your hearing exceptionally good? Yes_____ No_____

Do you have problems sleeping? Yes_____ No_____

How many hours of sleep do you normally get each night? _____

Spiritual Background

Religion: None_____ Christian _____ Jewish _____ Muslim _____ Agnostic _____ Other _____

Denominational Preference _____

Church Attending _____ Member? Yes No

Church Address _____

Phone () _____ Pastor's Name _____

Church attendance per month _____

Please describe your upbringing _____

Do you believe in God? Yes No Uncertain

How often do you pray to God? Daily Weekly Occasionally Never

How often do you read or study the Bible? Daily Weekly Occasionally Never

Would you say you are a Christian or still in the processing of becoming a Christian? _____

Do you believe that when you die, you will be with God eternally? Yes No Uncertain

What is your hope about eternity? _____

Have you been baptized? Yes No

Explain any recent significant changes in your religious life _____

What is your opinion of the Bible?

_____ I don't know enough about the Bible to have an opinion.

_____ It is a book that contains helpful principles that I am free to follow or disregard as I think best.

_____ It is a book that was inspired by God and that contains helpful principles and instructions I should follow unless I believe there is a good reason to do otherwise.

_____ It is a book that was inspired by God and that contains helpful principles, instructions, and commands that I should follow regardless of my feelings or preferences.

_____ Other / Explain _____

Who, if anyone, has the most influence on your religious or spiritual life? (Please list their names and their relationship to you) _____

Women Only

Have you had any menstrual difficulties? Yes No_____ If yes, please explain _____

Is your husband in favor of your coming for counseling? Yes No

If no, please explain _____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS

1. What is the main problem as you see it? (What brings you here)?

2. What have you done to try to resolve this problem or dispute?

3. What issues or questions do you want to have resolved or answered?

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

5. As you see yourself, what kind of person are you? Describe yourself.

6. Is there any other information we should know? _____
