PERSONAL DATA INVENTORY

(Please completely fill out this form and make it available to your counselor before your first counseling session.)

Name____

Address____

(Street) (City) (State) (Zip)

Sex_____Age_____Date of Birth_______________Phone________________

Occupation__________________Education/Training___________________

Business Address____Phone________________

Referred for counseling by_______________________________________

PERSONAL HISTORY

Parents: Name Age(if living) Occupation Marital Status

Father:____

Mother:____

Guardian Name (if applicable)__________________Relation to you_________________

Reason for Guardianship________________________Date________to________

Siblings: Name Age Relationship Marital Status

____

____

____

____

More than five? Yes No

Indicate which might have applied during your childhood and/or adolescence:

School problems_____Family problems_____Medical problems_____

Drug/Alcohol abuse problems_____Social problems_____Legal problems_____

Please explain:____

____

____

____

OCCUPATIONAL HISTORY

What jobs have you held in the past?

____

____

Does your present work satisfy you? If not, please explain.

____

____

Present annual income_______________________

MARITAL HISTORY

Marital Status: Single Engaged Married Remarried Separated Divorced Widowed

Your Present Marriage (if applicable)

Spouse's name________________________Age____Occupation__________

Spouse's religious background____________________Education__________

Date of marriage__________Have you ever been seperated from your present spouse?

If yes, please specify when: 1)______to______ 2)______to_______

Children

Name Relationship Living at Home Age Marital Status Occupation (son, step-daughter, etc.)

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____

____
____
____
Your Previous Marriages (if applicable)
Date Children from this marriage
________to________ ____________________________________
________to________ ____________________________________
Spouse's Previous Marriages (if applicable)
Date Children from this marriage
________to________ ____________________________________
________to________ ____________________________________
RELIGIOUS BACKGROUND
Denominational preference____
Church presently attended (name and address):
____Phone_______________
Pastor__________________________________Permission to consult with pastor: Yes No
Do you believe in God? Yes___No___Uncertain___
Do you consider yourself "Saved"? Yes___No___Not sure what you mean___
If you were to die and stand before God and He asked you why He should permit you to enter Heaven, how might you respond?
____
____
MEDICAL HISTORY
Have you had any of the following physical problems? Please check.
Heart problems__ Bulimia__ Menstrual irregularities__
Liver problems__ Anorexia__ Kidney problems__
Visual problems__ Hallucinations__ Head injury/concussion__
Sensory distortion__ Change in sexual drive__ Stroke__
Weakness__ Seizures__ Fatigue__
Problems walking__ Brain tumor__ Heat/cold sensitivity__
Unusual hair loss__ Multiple Sclerosis__ Rashes__
Parkinson's disease__ Bowel/bladder__ Memory problems__
Blackouts__ Nausea/vomiting__ Episodic disorientation__
Amnesia__ Weight change__ Tremors__
Impotence__ Personality change__ Thyroid dysfunction__
Physical change__ Deja vu__ Diabetes__
Constant hunger__ Changes in consciousness__ Hypoglycemia__
Food cravings__ Lung problems__ Fever__
Headaches__ Allergies__ Pneumonia__
Dizziness__ Cancer__ Speech Problems__
Stiff neck__ High Blood Pressure__ Incoordination__
List previous surgeries (those which required anesthesia)
List all prescription and over-the-counter medications: Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin.
What is your average daily caffeine consumption? Include coffee, tea chocolate, stimulants, and caffeinated soft drinks.
How many hours of sleep do you average each night? Have there been any recent changes? Is this sleep restful?
Have you or others noticed any changes in your personality (anger, mood swings, withdrawal) thinking and memory, or work habits?

As you see yourself, what kind of person are you? (describe yourself)

____

____

State in your own words the nature of the main problem(s) that bring you for counseling:

____

____

____

____

When did your problems begin? Please specify a date if possible.

____

____

Please describe any significant events occurring at that time.

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____

What have you done to try to resolve your problems(s)?

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What would you like us to do for you? What kind of help do you want from us?

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Is there any other information we should know?

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