



Healing Hearts • Restoring Relationships • Liberating Lives

PERSONAL DATA INVENTORY

Current Date _____

Case #: _____

EDUCATION

Please check the highest level of education completed: Some high school Completed high school

Some college/Associates degree Bachelor's degree Master's degree Post-graduate

Please list any specific educational difficulties _____

MARITAL STATUS

Please complete if you are currently engaged or dating

Date of meeting _____ Length of dating _____
Give a brief statement of circumstances of meeting and dating _____ _____
Are you planning to marry? _____ Expected date of wedding _____

Please complete if you are currently or have ever been married

Date of marriage _____ Briefly describe your relationship _____ _____
Is your spouse willing to come to counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you ever been separated? <input type="checkbox"/> Yes <input type="checkbox"/> No When _____ How long? _____
Have you been married before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe briefly _____ _____
Has your spouse been married before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe briefly _____ _____

Please list any siblings below:

Name	Age	Gender		
			<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Adopted <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling
			<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Adopted <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling
			<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Adopted <input type="checkbox"/> Step-sibling <input type="checkbox"/> Half-sibling
			<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Adopted <input type="checkbox"/> Step-sibling

				<input type="checkbox"/> Half-sibling
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MEDICAL HISTORY

Have you received therapy, counseling, or treatment in the past? Yes No When? _____

With whom? _____

Please describe any current medical condition or history pertinent to problem: _____

Please describe any family history of medical and/or psychological problems: _____

Are you taking any medications currently? Yes No If yes, please list them below:

Medication	Dosage	Frequency

Are you allergic to any medications? Yes No Please list _____

Please list your physician's name, address and phone number: _____

Would you sign a release of information form so your counselor may have access to psychiatric, medical or other records? Yes No

Please describe current or past drug/alcohol use:

Drug	Amount	Frequency of use	Currently using?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Please describe any past treatment for alcohol/drug abuse or dependence: _____

Please describe any family history of alcohol/drug abuse or dependence and/or treatment: _____

Please check any symptoms that you have had in the last six months:

<input type="checkbox"/>	Change in appetite (increase or decrease)
<input type="checkbox"/>	Difficulty sleeping/ insomnia
<input type="checkbox"/>	Sleeping too much
<input type="checkbox"/>	Fatigue/ low energy
<input type="checkbox"/>	Low self-esteem
<input type="checkbox"/>	Tearful/ crying spells
<input type="checkbox"/>	Hopelessness

<input type="checkbox"/>	Problems concentrating
<input type="checkbox"/>	Low Motivation
<input type="checkbox"/>	Isolating from others
<input type="checkbox"/>	Frequent anger
<input type="checkbox"/>	Depressed mood/ sadness
<input type="checkbox"/>	Anxiety/ fear
<input type="checkbox"/>	Panic

SPIRITUAL

Do you believe in God? Yes No

Do you pray? Yes No

Are you still in the process of becoming a Christian? Yes No

Are you a Christian? Yes No If yes, when did you become a Christian? _____

Church attendance per month _____ How often do you read the Bible? _____

Positions held in the church _____

Please explain any recent changes in your religious life _____

EMOTIONAL

Please *circle* any of the following that best describe you *now*:

- | | | | | | |
|-----------|-------------|----------------|------------|--------------|----------------|
| active | ambitious | self-confident | shy | hardworking | persistent |
| nervous | impatient | impulsive | moody | kindly | excitable |
| calm | imaginative | serious | easy-going | good-natured | introvert |
| extrovert | likable | leader | quiet | lonely | self-conscious |
| sensitive | submissive | rebellious | fearful | bitter | Other: _____ |

Please describe concerns that brought you here today: _____

What have you done in attempting to resolve these problems? _____

What are your goals for counseling? _____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that bring you to counseling (your relationship with your parents, their relationship with each other, significant losses and/or events): _____

Please describe any current or past violence or abuse in the home: _____

Please describe any current or past thoughts, which are suicidal: _____

Please describe any current thoughts, which are homicidal: _____

Is there any other information we should know? _____

Thank you for taking the time to complete this form. The information you have provided will enable us to better serve your needs.