The Biblical Counseling Ministry
Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name:_____Birth Date:_____Phone: _____

Email:_____ Age:_____ Sex:_____ Referred By: _____

Address:_____ Zip Code:_____

Marital Status: ◯ Single ◯ Engaged ◯ Married ◯ Separated ◯ Divorced ◉ Widowed

Education (last year completed): _____

Employer:_____Position: _____

Years:_____Work Phone:_____Weekly Work/School Hours:_____

Marriage and Family

Spouse:_____ Birth Date:_____Age: _____

Occupation:_____ How Long Employed: _____

Home Phone:_____ Work Phone: _____

Date of Marriage:_____ Length of Dating: _____

Give a brief statement of circumstances of meeting and dating: _____

_____

Have either of you been previously married:_____To Whom: _____

Have you ever been separated:_____ Filed for divorce: _____

Information about Children:

First Name:_____ Age:_____ Sex:____Living: _____ Year Ed.: _____ Step-Child:____

Second Name:_____ Age:_____ Sex:____Living: _____ Year Ed.: _____ Step-Child:____

Third Name:_____ Age: _____ Sex:____Living: _____ Year Ed.: _____ Step-Child: ____

Fourth Name:_____ Age: _____ Sex:____Living: _____ Year Ed.: _____ Step-Child: ____

Fifth Name: _____ Age: _____ Sex:____Living: _____ Year Ed.: _____ Step-Child: ____

Sixth Name: _____ Age: _____ Sex:____Living: _____ Year Ed.: _____ Step-Child: ____

Parents still married:_____Parents living:_____Parents live locally: _____

Parent's religious convictions, were/are they believers:_____

_____

Describe relationship to your father: _____

_____

Describe relationship to your mother: _____

_____

Number of sibling(s):_____Your sibling order: _____

Do you or did you live with anyone other than parents: _____

Health

Describe your overall health:_____

Do you have any chronic conditions, important illnesses, injuries and/or handicaps: _____

_____

_____

Date of last medical exam:_____Report: _____

Do you have a family doctor or physician you see regularly:_____

Current medication(s) and dosage: _____

_____

Have you ever-used drugs for anything other than medical purposes:_____If yes, please explain:

_____

_____

Have you ever been arrested: _____ Do you drink alcoholic beverages: _____

If so, how often & how much: _____ Do you drink coffee:_____ How much:_____

Other caffeine drinks: _____ How much: _____

Use tobacco: _____ What: _____ Frequency: _____

Describe your normal sleeping schedule: _____

Have you ever had interpersonal problems on the job? If so, please describe: _____

_____

Have you ever had a severe emotional upset:_____If yes, please explain:_____

_____

Have you ever seen a psychiatrist or counselor:_____If yes, please 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

Denominational preference:_____Church attending:_____

Member:_____Pastor's Name:_____Pastor's Phone Number:_____

Church attendance per month: Do you believe in God:_____ Do you pray: _____

Would you say that you are a Christian:_____, OR still in the process of becoming a Christian: _____

_____Have you ever been baptized: _____

How often do you read the Bible: Are you involved in ministry:_____

Have you ever been discipled? If yes, please describe: _____

_____

Explain any recent changes in your religious life: _____

_____

What are the three biggest positive influences on your spiritual life:_____

_____

What are the three biggest negative influences on your spiritual life:_____

_____

Have you shared the problems for which you are seeking counseling with your pastor and/or other mature members of your church? If yes, please write down their names. If no, please describe any concerns you have about doing so: _____

_____

_____

Women Only

Have you had any menstrual difficulties:_____ If you experience tension, tendency to cry, other symptoms prior to your cycle, please explain: _____

Is your husband willing to come for counseling: _____ Is he in favor of your coming:_____

If no, please explain: _____

_____

Problem Severity: Please rate how these items impact your life

(blank) = no significant impact; 1= mild impact; 2 = moderate impact; 3 = severe impact

_____Anger
_____Anxiety
_____Apathy
_____Appetite
_____Bitterness
_____Change in lifestyle
_____Children
_____Communication
_____Conflict (fights)
_____Control
_____Deception
_____Decision Making
_____Depression
_____Disciplined Living
_____Disorganization
_____Discouraged/Downcast
_____Drunkenness
_____Envy
_____Fear
_____Finances
_____Gluttony
_____Guilt
_____Health
_____Homosexuality
_____Impotence
_____In-laws
_____Laziness
_____Loneliness
_____Lust
_____Marriage
_____Memory
_____Moodiness
_____Overwhelmed
_____Perfectionism
_____Pornography
_____Procrastination
_____Rebellion
_____Sexual Immorality
_____Sex (in marriage)
_____Sleep
_____Spouse Abuse
_____Time Usage
_____Weary
_____Other

Briefly Answer the Following Questions

1. Why have you sought counseling? What difficulties are you facing?

2. What have you done about the difficulties?

3. What are your expectations from counseling?

4. Is there any other information that we should know?