Personal Data Inventory

Today’s Date:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education/Training\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred for Counseling by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Personal History

Parents: Name Age (if living) Occupation Marital Status

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother:

Guardian Relation to you \_\_\_\_\_\_\_\_\_\_\_

(if applicable)

Date\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Reason for Guardianship\_

Siblings: Name Age Relationship Marital Status

More than Five? Yes No

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

Emotional/behavioral problems\_\_\_\_\_ School Problems \_\_\_\_\_\_ Family Problems \_\_\_\_\_\_

Medial Problems \_\_\_\_\_ Drug/Alcohol abuse problems \_\_\_\_\_ Social Problems \_\_\_\_\_

Legal Problems \_\_\_\_\_

Has anyone in your immediate family been hospitalized or received some form of professional help for psychological problems? If so, please specify who, when they received help, and the nature of the problem.

# Occupational History

What positions have you held in the past?

Does your present work satisfy you?

# 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 separated 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.)

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 attending (name & 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 that means?

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 \_\_\_\_ Cancer \_\_\_\_ Speech Problems \_\_\_\_

Liver Problems \_\_\_\_ Bulimia \_\_\_\_ Poor coordination \_\_\_\_

Kidney problems \_\_\_\_ Anorexia \_\_\_\_ Menstrual irregularities \_\_\_\_

Head injury/ Visual problems \_\_\_\_ Hallucinations \_\_\_\_

Concussion \_\_\_\_ Sensory distortions \_\_\_\_ Change in sexual drive \_\_\_\_

Stroke \_\_\_\_ Weakness \_\_\_\_ Problems walking \_\_\_\_

Seizures \_\_\_\_ Fatigue \_\_\_\_ Unusual hair loss \_\_\_\_

Brain Tumor \_\_\_\_ Heat/Cold Rashes \_\_\_\_

Multiple Sclerosis \_\_\_\_ sensitivity \_\_\_\_ Memory problems \_\_\_\_

Parkinson’s Disease \_\_\_\_ Bowel/Bladder Episodic disorientation \_\_\_\_

Blackouts \_\_\_\_ Problems \_\_\_\_ Personality change \_\_\_\_

Amnesia \_\_\_\_ Nausea/Vomiting \_\_\_\_ Déjà vu \_\_\_\_

Tremors \_\_\_\_ Impotence \_\_\_\_ Recent weight loss \_\_\_\_

Thyroid Dysfunction \_\_\_\_ Physical change \_\_\_\_ Changes in consciousness \_\_\_\_

Diabetes \_\_\_\_ Constant hunger \_\_\_\_ Headaches \_\_\_\_

Hypoglycemia \_\_\_\_ Food cravings \_\_\_\_ Dizziness \_\_\_\_

Lung Problems \_\_\_\_ Fever \_\_\_\_ Stiff neck \_\_\_\_

Allergies \_\_\_\_ Pneumonia \_\_\_\_ High blood pressure \_\_\_\_

List previous surgeries (those which required anesthesia)

List all prescription and over-the-counter medications: Include diet pills, laxatives, birth control pills, cold & allergy medicines, and 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?

State in your own words the nature of the main problem(s):

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

Please specify any significant events occurring during that time.