# PERSONAL DATA INVENTORY

## PERSONAL DATA

Name: ____________________________________________ Home Phone: _____________________
Address: ______________________________________________________________________________________
Email: ______________________________________________ Work Phone: _____________________
Occupation: ____________________________ Education: (highest completed): _________
Other training: ____________________________________
Birth Date: ______________ Age: ______ Sex: M ☐ F ☐
Separated:☐ Divorced :☐ Widowed:☐ Single:☐ Married:☐ Remarried:☐

Referred here by: ___________________________________ Phone: _____________________

## PHYSICAL HEALTH

Please check any of the following physical problems that would apply to you:

☐ Allergies
☐ Amnesia
☐ Anorexia
☐ Blackouts
☐ Bowel/bladder
☐ Brain Tumor
☐ Bulimia
☐ Cancer
☐ Changes in Consciousness
☐ Changes in Sexual Drive
☐ Constant Hunger
☐ Déjà vu
☐ Dizziness
☐ Episodic Disorientation
☐ Fatigue
☐ Food Cravings
☐ Hallucinations
☐ Head Stroke
☐ Headaches
☐ Heart Problems
☐ Heat/Cold Sensitivity
☐ High Blood Pressure
☐ Impotence
☐ Incoordination
☐ Injury/Concussion
☐ Kidney Problems
☐ Liver Problems
☐ Lung Problems
☐ Memory Problems
☐ Menstrual Irregularities
☐ Multiple Sclerosis
☐ Nausea/Vomiting
☐ Parkinson's Disease
☐ Personality Change
☐ Physical Change
☐ Pneumonia
☐ Problems Walking
☐ Rashes
☐ Seizures
☐ Sensory Distortion
☐ Speech Problems
☐ Stiff Neck
☐ Unusual Hair Loss
☐ Visual Problems
☐ Weakness
☐ Weight Change

Rate your health: Very Good ☐ Good ☐ Average ☐ Declining ☐ Other ☐ ______________________

Your approximate weight: _____lbs Recent weight changes: ______lbs ( ☐ Loss ☐ Gain )

List all important, present, or past, injuries or handicaps: ___________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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 etc. ____________________________________________________________
____________________________________________________________________________________

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, irritability, withdrawal) thinking and memory, or work habits? ___________________________________________________________

Have you ever had a severe emotional upset? Yes ☐ No ☐
Explain: ___________________________________________________________________________________

Have you recently suffered loss from serious social, business, or other reversals? Yes ☐ No ☐

Have you recently suffered loss of someone who was close to you? Yes ☐ No ☐

## SPIRITUAL HEALTH

Church currently attending: ________________________________Are you a member? Yes ☐ No ☐
Have you gone to them for help? Yes ☐ No ☐
Church attendance per month:
Church attended in childhood ___________________ Were you baptized? Yes ☐ No ☐
Religious background of spouse (if married):_______________________________________________
Do you consider yourself a religious person? Yes ☐ No ☐ Uncertain ☐ _______________________
Do you believe in God? Yes ☐ No ☐ Uncertain ☐ __________________________________________
Do you pray to God? Never ☐ Occasionally ☐ Often ☐ _____________________________________
Are you saved? Yes ☐ No ☐ Not sure what you mean ☐ ____________________________________
How much do you read the Bible? Never ☐ Occasionally ☐ Often ☐ __________________________
Do you have regular family devotions? Yes ☐ No ☐
Have there been any changes in your religious life, explain: ______________________________________
____________________________________________________________________________________

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? ______________________________________________________________________
____________________________________________________________________________________

## PERSONAL/BEHAVIORAL INFORMATION

Have you ever had psychotherapy or counseling before? Yes ☐ No ☐
If yes, list counselor and dates: ______________________________________________________________
What was the outcome? ______________________________________________________________________

Please check any of the following words which best describe you now:

| | | | |
|---|---|---|---|
| ☐ Abusive | ☐ Ambitious | ☐ Calm | ☐ Easy-going |
| ☐ Active | ☐ Angry | ☐ Cruel | ☐ Embarrassing |
| ☐ Ethical | ☐ Imaginative | ☐ Moody | ☐ Sensitive |
| ☐ Excitable | ☐ Impatient | ☐ Nervous | ☐ Serious |
| ☐ Extrovert | ☐ Impulsive | ☐ Often-blue | ☐ Shy |
| ☐ Godly | ☐ Introvert | ☐ Persistent | ☐ Strict |
| ☐ Good-natured | ☐ Irresponsible | ☐ Proud | ☐ Submissive |
| ☐ Hard-boiled | ☐ Leader | ☐ Quiet | ☐ Uneducated |
| ☐ Hardworking | ☐ Likable | ☐ Self-confident | ☐ Unreasonable |
| ☐ Hypocritical | ☐ Lonely | ☐ Self-conscious | |

Add at least two more_______________________________________________________________

| | | |
|---|---|---|
| Have you ever felt people watching you? | Yes ☐ | No ☐ |
| Do people's faces ever seem distorted? | Yes ☐ | No ☐ |
| Do colors ever seem too bright? | Yes ☐ | No ☐ |
| Are you sometimes unable to judge distance? | Yes ☐ | No ☐ |
| Have you ever had hallucinations? | Yes ☐ | No ☐ |
| Are you afraid of being in a car? | Yes ☐ | No ☐ |
| Is your hearing exceptionally good? | Yes ☐ | No ☐ |
| Do you have problems sleeping? | 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 ☐ Sexual abuse
Please Explain: ____________________________________________________________________________
____________________________________________________________________________________________

## MARRIAGE AND FAMILY INFORMATION

Name of Spouse: _______________________ Address: __________________________________________
Phone: _______________ Occupation: _____________________________ Work Phone: _______________
Spouse's age: _____ Education (highest completed) ________ Religion: __________________________
Is spouse willing to come for counseling? Yes ☐ No ☐ Uncertain ☐ _________________________
Have you ever been separated? Yes ☐ No ☐ When? From ____________ to __________
Have either of you ever filed for divorce? Yes ☐ No ☐ When? ______________________________
Date of marriage: _____________ Ages when married: Husband _____ Wife _____
How long did you know your spouse before marriage? ___________________________________________
Length of steady dating with spouse: _________ Length of engagement: _________

Give brief information about any previous marriages: ____________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Information about children (PM=Children from previous marriages)

| PM (✓) | Name | Age | Sex | Living (Y or N) | Education | Marital Status | Living with you? (Y or N) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

If you were reared by anyone other than your parents, explain: ____________________________________
_____________________________________________________________________________________

How many older siblings do you have? ______ brothers ______ sisters
How many younger siblings do you have? ______ brothers ______ sisters

## OCCUPATIONAL HISTORY

What jobs have you held in the past?_________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Does your present work satisfy you? If not, please explain: _______________________________________
_____________________________________________________________________________________

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

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

When did it start? Please specify a date if possible: __________________________________________________
________________________________________________________________________________________

Please describe any significant events occurring at that time: __________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. What have you done about it? ___________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

3. What do you want us to do about it? ______________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

4. As you see yourself, what kind of person are you? (describe yourself) ______________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

5. Is there any other information we should know? ____________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

6. What, if anything, do you fear? ____________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________