Personal Data Inventory

HARVEST BIBLE CHAPEL TRAVERSE CITY

Identification Data:

Date: _____

Name: _____ Home Phone: _____

Cell Phone: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Birth Date: _____ Age: _____

Occupation: _____ Place of Business: _____

Marital Status: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed ___

Education (number of years completed): High School_____ College _____ Post College_____

Major: _____ Other training:_____

Referred here by: _____

Health Information:

Rate your current Physical health: Good ___ Average ___ Declining ___ Poor ___

Height: _____ Weight: _____ Recent weight changes: Lost: _____ Gained: _____

List all important present or past illnesses, injuries or handicaps: _____

_____

Date of last medical examination: _____ Results: _____

_____

Physician's name: _____

Have you ever had a severe emotional upset? _____

_____

Do you drink alcoholic beverages? Yes ____ No ____ If so, how frequently and how much: _____

Have you ever had a problem with alcohol or drug abuse (prescription or non-prescription)? _____

Have you ever been physically abused as a child or as an adult? _____

Have you ever been sexually molested, either as a child or as an adult? _____

Have you seen a psychologist, psychiatrist and/or counselor? _____

If yes, list counselors or therapists, and dates: _____

_____

Are you willing to sign a release of information form so that our Biblical Soul Care Ministry may write to request helpful social, psychiatric, or medical reports? Yes ____ No ____

Have you ever been arrested? Yes: ___ No: ___ If yes, for what reason? _____

Have you ever used drugs for other than medical purposes? Yes: ____ No: ____

Are you presently taking any medication? Yes: ____ No: ____ Prescribed? Yes: ____ No: ____

By whom? _____ Over the counter? Yes: ____ No: _____

Medications and Dosage: _____

Religious Background:

Current church you attend (if any): _____

Church attendance per month (circle): 0 1 2 3 4 5 6 7 8 9 10+

Which Small Group are you part of (if any): _____

Church attended in childhood: _____ Baptized? Yes ___ No ___

Religious background and current church attended by spouse, if married: _____

Are you saved? Yes: ___ No: ___ Not sure what you mean: _____

How often do you read the Bible? _____

Would you say that you are a Christian? _____

Marriage Information:

NOTE: If never married, check here: _____, and skip to the "Family Information" section.

Name of spouse: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Occupation: _____ Place of Business: _____ Phone: _____

Your spouse's age: _____ Education (years): _____ Is your spouse willing to come in for counseling? _____

Have you ever been separated? Yes: _____ No: _____ If yes, when? From: _____ To: _____

Has either of you ever filed for divorce? Yes: ___ No: ___ If yes, when? _____

Date of this marriage: _____ Your ages when married: Husband: _____ Wife: _____

How long did you know your spouse before marriage? _____

Length of steady dating with spouse: _____ Length of engagement: _____

Have either of you been previously married? _____ To Whom: _____

Give brief information about any previous marriages: _____

Is your spouse in favor of you coming here to receive counseling? _____ If no, please explain: _____

_____

Family Information:

Describe relationship to your father: _____

Describe relationship to your mother : _____

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

Did you live with anyone other than parents: _____

Are your parents living? _____

Do you have significant debt in any of the following areas:

_____ Home _____ Car _____ School _____ Credit Cards

Are you involved in or do you anticipate being involved in legal actions: _____ Yes _____ No

Information about Children:

*PR	Name	Age	Sex	Is child still living in your home? (Yes/No)

*Check this column if child is by previous relationship

Problem Check List:

We are grateful to the Lord for the opportunity to meet with you and sincerely desire to understand what is happening in your life. This checklist is a way for us to gather more information about what is going on in your life. You can check as many boxes as you need.

_____ Anger
_____ Anxiety
_____ Apathy
_____ Appetite
_____ Bitterness
_____ Change in Lifestyle
_____ Children
_____ Communication
_____Conflict (fights)
_____ Deception
_____ Decision Making
_____ Depression
_____Drunkenness
_____Eating Problems
_____ Envy
_____ Fear
_____ Finances
_____ Gluttony
_____ Guilt
_____ Health
_____ Homosexuality
_____ Impotence
_____ In-laws
_____ Loneliness
_____ Loss of Loved One
_____ Lust
_____ Memory
_____ Moodiness
_____ Perfectionism
_____Pornography
_____ Rebellion
_____ Sex
_____ Sleep
_____ Spousal Abuse
_____ A Vice
_____ Other

Describe the Situation:

It will be helpful to have at least a few sentences or short paragraph for each question below. If additional space is needed, please feel free to answer the question in a separate document. Thank you for your help, and we will be prayerfully anticipating our meeting.

Situation: What seems to be the main problem?

Thinking: What do you think or wonder about yourself in relation to the situation? What do you think of others in relation to the situation?

Others: How are others involved? How does this issue impact others? What have others done to compound or alleviate the problem?

Response: What are you doing about this issue? What have you done to try to address this issue in the past? What are your typical actions or reactions to this problem (e.g. "I get angry and go for a drive")? In general, when you are feeling pressure in life, how does it come out? What do you do? How are you sleeping?

Emotions: What do you fear? What would give you peace, related to this situation? What is the emotion you are struggling with the most?