Association of Certified Biblical Counselors

PERSONAL DATA INVENTORY

Date | |

Please be aware that there are no wrong or right answers to the following questions. Your honest answers will help us to know and serve you better.

PERSONAL INFO

Name:	Sex: ☐ Male ☐ Female	Age
Email:	Date of Birth: | |	
Best phone number to reach you: ( )		
Address:		
Education (last year completed):		
Current Occupation (or responsibility):		
How many hours do you work in a week at your job?		

Who do you live with (their relationship to you)? _____

Help us get to know you. Mark on each continuum line below how you would describe yourself, generally.

More Analytical	_____	More Creative		More Energetic	_____	More Calm/Sedate	
More Out-going	_____	More Shy		More of a Leader	_____	More of a Follower	
More Easy-going	_____	More Serious		More of an Open Book	_____	Harder to get to Know	
More Decisive	_____	More Unsure		More Confident	_____	More Nervous	
More Introverted	_____	More Extraverted		More often Happy	_____	More often Sad	
More Dependable	_____	More Forgetful		More Sensitive	_____	More Direct/Blunt	
More of a hard-worker	_____	More of a Procrastinator		More Moody	_____	More Even-Tempered	
More Logical	_____	More Feeling led		More Others-minded	_____	More in my own World	

More of a Fixer	_____	More of a worrier		More Self-Conscious	_____	More Care-free	
More Organized	_____	More Haphazard		More Cautious	_____	More Spontaneous	
More Independent	_____	More Reliant		More Gracious	_____	More Critical	
More Slow to Act	_____	More Impulsive		More Patient	_____	More Impatient	
More Go w/the Flow	_____	more Controlling		More People Oriented	_____	More Project Oriented	

Are you in a significant relationship other than marriage? Explain and include how long:

_____

MARRIAGE AND FAMILY INFO

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Spouse's Name:	Length of Marriage:
Spouse's Current Occupation (or responsibility):	Weekly Hours:

Children's Names:	Age	Sex	Are they Living?	By Previous Marriage?

Have you ever been separated before? ☐ Yes ☐ No

If yes, please explain: _____

Has either of you ever considered or filed for divorce? ☐ Yes ☐ No

If yes, please explain: _____

Have you been married before? ☐ Yes ☐ No

If yes, please explain: _____

Is your spouse in favor of your coming to counseling? ☐ Yes ☐ No

Is your spouse willing to come to counseling (if needed)? ☐ Yes ☐ No

HEALTH INFO

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

Date of last medical exam: _____ Report: _____

Physician's name: _____ Address: _____

List all prescriptions and over-the counter medications you are currently taking (Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, etc.). *Continue on back as needed

Med: _____ For What? _____

Med: _____ For What? _____

Med: _____ For What? _____

Med: _____ For What? _____

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

_____

_____

_____

Do you have any chronic medical conditions?_____

Have you used drugs for other than prescribed medical purposes? ☐ Yes (Past) ☐ Yes (Now) ☐ No

What Drug? _____ How Long? _____

Have you used more than the prescribed amount of any medication? ☐ Yes (Past) ☐ Yes (Now) ☐ No

What Drug? _____ Amount: _____How Long? _____

How much of the following type of beverages do you consume daily or weekly?

Alcohol _____ Coffee _____ Tea _____ Soft Drink _____ Water _____

On a scale of 1-10, how healthy do you eat? _____ Do you smoke? ☐ Yes ☐ No

How often do you exercise? _____ Times/Week ☐ Rarely ☐ Never

How many hours of sleep do you average each night? _____

Has there been any recent change? _____

Is this sleep uninterrupted? _____

Have you ever experienced hallucinations, seen distorted faces, or heard voices? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a severe emotional upset? If so, please explain: _____

_____

Have others noticed any significant changes in your emotional or mental state, memory, or work abilities?

_____

_____

Are you willing to sign a release of information so that your counselor may write for any counseling and medical information that might be helpful? ☐ Yes ☐ No

BACKGROUND INFO

Please answer these background questions to the best of your ability, so we might minister to you more sensitively and wisely. These questions are **not** meant to imply: 1) that we cannot now know God as sovereign, good and sufficient regardless of our past, 2) that God cannot use our past for good, 3) that our past is our identity nor, 4) that we will/must be determined by our past.

Were you raised by both biological parents? ☐ Yes ☐ No

If no, please explain: _____

Rate your parent's marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Are/were your parents divorced? ☐ Yes ☐ No Explain briefly when, and the basic circumstances:

_____

_____

Describe your relationship with your mother: _____

_____

Describe your relationships with your father: _____

_____

How many older siblings do you have? Brothers _____ Sisters _____

How many younger siblings do you have? Brothers _____ Sisters _____

Describe your relationships with your siblings: _____

_____

_____

Check all the following that best describe the parenting style of your childhood (M=Mother, F=Father):

Excessively authoritative/ Very high control	☐ M ☐ F	Rules/Instructions without relationship	☐ M ☐ F
Excessively permissive/ Too low control	☐ M ☐ F	Disengaged/ Excessively preoccupied	☐ M ☐ F
Generally balanced leadership/Authority	☐ M ☐ F	Caring involvement/ Instruction	☐ M ☐ F
Manipulative (selfish, angry, guilt trip)	☐ M ☐ F	Perfectionistic/very performance driven	☐ M ☐ F
Leading by example	☐ M ☐ F		

Check all the following that best describe the predominant atmosphere(s) in your home as a child:

☐ Happy	☐ Secure/Safe	☐ Open/Honest	☐ Truly Christian
☐ Sad/Depressing	☐ Tumultuous/ Uncertain	☐ Closed off/Private	☐ Outwardly-religious
☐ Calm/Relaxed	☐ Angry/Hostile	☐ Loving/Encouraging	☐ Non-Christian

Was there any substance abuse in your family? ☐ Yes ☐ No

If yes, please explain: _____

<u>Other and Later Life:</u>

Other than your parent(s), describe people in your life who have had a significant influence in your life (positive or negative): _____

_____

Has there been any abuse in your past? ☐ Physical ☐ Verbal/Emotional ☐ Sexual ☐ No

If yes, by whom? _____ What age? _____

Have you ever seen a psychologist, psychiatrist or received counseling before? ☐ Yes ☐ No

If yes, list counselor(s): _____and dates ____ / ____ /____ to ____ /_____ /_____

_____and dates ____ / ____ /____ to ____ /_____ /_____

_____and dates ____ / ____ /____ to ____ /_____ /_____

What were you seen for? _____

What was the outcome? Was it helpful? _____

_____

Do you carry significant guilt? ☐ Yes ☐ No

If yes, for what? _____

Any job difficulties? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been arrested? ☐ Yes ☐ No When? _____

Describe the circumstances:_____

Describe any recent, significant event(s) in your life (i.e. job loss, birth, death, successes, etc.):

_____

_____

SPIRITUAL LIFE INFO

Church/religious experience as a child (Denomination and length of time): _____

_____

Church/religious experience as an adult (Denomination and length of time): _____

_____

Do you attend a local Christian church? ☐ Yes ☐ No

Name of the church you attend: _____

Are you a member? ☐ Yes ☐ No How long? _____

Have you been baptized? ☐ Yes ☐ No At what age? _____

Church services/functions attended per month: _____

Are you part of a Small Group: ☐ Yes ☐ No Who is your Small Group leader: _____

Do you attend church with your spouse? ☐ Yes ☐ No

If no, please explain: _____

Do you consider yourself as "saved"? ☐ Yes ☐ No ☐ Not sure what you mean

Does your spouse consider himself/herself as "saved"? ☐ Yes ☐ No ☐ Don't know

Have you come to the place in your spiritual life where you know with certainty that you would enter heaven after death? ☐ Yes ☐ No

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? _____

_____

Explain recent changes in your spiritual life, if any: _____

_____

How often do you pray to God? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

How often do you read the Bible? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Do you regularly give financially to the church/God's work? ☐ Yes ☐ No

Do you serve at your church? How? _____

PROBLEM CHECK LIST

Please mark 1-3 on all that apply (1=Mild, 2=Moderate, 3=Severe). Circle where there are options.

____ Abuse at present (sexual, Physical, verbal)	____ Drunkenness	____ Memory
____ Anger	____ Drugs	____ Mental confusion
____ Anorexia	____ Envy or jealousy	____ Moodiness
____ Anxiety	____ Fear	____ Overwhelmed
____ Apathy	____ Finances	____ Perfectionism
____ Bitterness	____ Gambling	____ Poor concentration
____ Bulimia	____ Gluttony	____ Pornography

____ Children
____ Communication
____ Conflict (Fights)
____ Deception
____ Decision making
____ Depression
____ Drastic change in life circumstances/life style
____ Guilt
____ Grief
____ Health
____ Homosexuality
____ Infidelity
____ In-laws
____ Loneliness
____ Procrastination
____ Rebellion
____ Same sex attraction
____ Self-injury
____ Sex (lust, impotence…)
_____
____ Sleep
____ Other
_____

PRE-COUNSELING QUESTIONS

Please take some time to think through what has been happening in your life that brings you to counseling. This section will help us get to know your current situation better, in order to match you with a counselor and/or provide the best help. Use the following questions as a guide to journal about what is going on in your life and heart.

1. What has brought you here? Describe the main problem in your life as you see it. (Include when it began and any other very significant events or information.)

_____

_____

_____

_____

_____

_____

_____

_____

2. What have you done to try and resolve the problem on your own?

_____

_____

_____

_____

3. Why are you now wanting to seek help?

4. What types of thoughts come to your mind in your current situation when you feel disappointed, discouraged, angry and/or fearful about the situation?

5. What are you hoping we can do for you?

6. Is there any other information you think we should know?

SCHEDULING

Please check the time and days that you are available for counseling.

	SUN	MON	TUE	WED	THU	FRI	SAT
Early morning (6am-9am)							
Morning (9am-12pm)							
Early afternoon (12pm-3pm)							
Afternoon (3pm-6pm)							
Evening (6pm-9pm)							

Do you have flexibility with your schedule? ☐ Yes, on these days _____ ☐ No