BIBLICAL COUNSELING

PERSONAL DATA INVENTORY

Please complete this form carefully and thoroughly
Return upon completion. By Email: Russ@faithchurchgallatin.org
Or by postal mail to: **FAITH CHURCH COUNSELING MINISTRIES**
Counseling-Russ Weymouth
639 S. Water Ave. Gallatin, TN 37066

PERSONAL IDENTIFICATION

Name _____ Birth Date_____

Address _____ Zip _____

Age _____ Sex _____ Email _____

Marital Status: Single ____ Engaged ____ Married ____ Separated ____ Divorced ____ Widow __

Home Phone _____ Cell _____ Work _____

Occupation _____ Employer _____ Years _____

Education (last yr. completed) _____ Where _____

Other Training: (list type & years completed) _____

Referred by: (list name and address if known) _____

Hobbies: _____

Other significant time/financial commitments: _____

MARRIAGE & FAMILY

Spouse _____ Birth Date _____ Home/Cell Phone _____

Occupation _____ Years Employed _____ 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 _____ Who _____

Have you ever been separated _____ When _____ Ever filed for Divorce _____

Information about Children:

Name	Age	Sex	Living Y/N	Step-child Y/N	Marital Status

Describe your relationship with your father _____

_____

Describe your relationship with your mother _____

_____

Number of siblings _____ Your sibling order _____

Did you live with anyone other than parents _____

Are your parents living _____ Do they live locally _____

HEALTH

Describe your general health _____

Do you have any chronic conditions _____ What _____

List important illnesses and injuries or handicaps _____

_____

Date of last medical exam _____ Report _____

Physician's name and address _____

Current medication(s) and dosage _____

_____

Have you ever used drugs for other than medical purposes _____

If yes, please explain _____

Have you ever been arrested _____ For what _____

Do you drink alcoholic beverages _____ If so, how frequently and how much _____

Do you drink coffee _____ How much _____ Other caffeine drinks _____

How much _____

Do you smoke _____ What _____ Frequency _____

Recent Weight Changes: _____ Gained _____ Lost

Have you recently suffered the loss of someone close to you: yes _____ no _____

Have you ever had interpersonal problems on the job _____ If yes, explain _____

_____

Have you ever had a severe emotional upset _____ If yes, explain _____

_____

Have you ever seen a psychiatrist or counselor _____ If yes, 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 _____

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

Do you believe in God _____ Do you pray _____ Would you say you are a Christian _____

Or, still in the process of becoming a Christian _____

Have you been baptized _____ If yes, how old were you _____

How often do you read the Bible: Never _____ Occasionally _____ Often _____ Daily _____

Explain any significant changes in your religious life _____

WOMEN ONLY

Have you had any menstrual difficulties _____ Do 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, explain _____

_____

PROBLEM CHECK LIST: Please rate how these items impact your life
(blank) = no significant impact; 1 = mild impact; 2 = moderate impact; 3 = severe impact

_____ Anger	_____ Anxiety (worry)	_____ Apathy (don't care)
_____ Appetite	_____ Bitterness	_____ Change in lifestyle
_____ Children	_____ Communication	_____ Conflict (fights)
_____ Control	_____ Deception	_____ Decision-making
_____ Depression	_____ Discouraged/Downcast	_____Drunkenness
_____ Envy	_____ Fear	_____ Finances
_____ Gluttony	_____ Guilt	_____Health
_____ Homosexuality	_____ Impotence	_____ In-laws
_____ Laziness	_____ Loneliness	_____ Lust
_____ Memory	_____ Moodiness	_____ Overwhelmed
_____ Perfectionism	_____ Pornography	_____ Procrastination
_____ Rebellion	_____ Sexual Immorality	_____ Sex (in marriage)
_____ Sleep	_____ Spouse Abuse	_____ Time Usage
_____ Weary	_____ A Vice	_____ Other

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is your problem (what brings you here)?

2. What have you done about this problem?

3. What are your expectations from counseling?

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