PERSONAL DATA INVENTORY (short form)

PLEASE COMPLETE THIS FORM BEFORE YOUR FIRST SESSION!

Your first session is:

Name:_____Date of Birth:_____

Email:_____ Phone: _____

Address:_____ City/State/Zip:_____

Referred for counseling by:_____

Sex: _____Age: _____ Cell phone: _____

HISTORY
Parents names:
Father:_____
Mother:_____
Siblings (names, ages):_____

Relationship with parents/siblings: Excellent Good Fair Poor
Comments:_____
_____

Marital status:
Single Engaged Married Remarried Separated Divorced Widowed
(circle all that apply)

Spouse's name: _____
Date of marriage:_____
Children (names, ages): _____

OCCUPATION
What jobs have you held in the past starting with your most current job:_____
_____
_____

Approximate current annual income:_____

RELIGIOUS BACKGROUND
Church currently attending:_____ Phone:_____

Pastor's name:_____ Permission to contact pastor: YES NO

Do you believe in God? YES NO UNCERTAIN

Do you consider yourself saved/born again/converted by Jesus? YES NO Not Sure What This Means

MEDICAL HISTORY

Please indicate the date of your last physical check up _____

Have you had any of the following physical problems? (Please circle all that apply)

Heart problems	Bulimia	Menstrual irregularities
Liver problems	Anorexia	Hallucinations
Kidney problems	Visual problems	Change in sex drive
Head injury/concussion	Sensory distortions	Problems walking
Stroke	Weakness	Unusual hair loss
Seizures	Fatigue	Rashes
High blood pressure	Heat/cold sensitivity	Memory problems
Multiple Sclerosis	Bowel/bladder problems	Episodic disorientation
Parkinson's disease	Nausea/vomiting	Personality change
Blackouts	Impotence	Déjà vu
Amnesia	Physical changes	Changes in consciousness
Tremors	Constant hunger	Headaches
Thyroid dysfunction	Food cravings	Dizziness
Diabetes	Fever	Stiff neck
Hypoglycemia	Pneumonia	Speech problems
Asthma	Cancer	Allergies

Please list previous surgeries (those requiring anesthesia)

List all prescription and over-the-counter medication: including diet pills, laxatives, birth control pills, cold and allergy medications, aspirin, etc.

How many hours of sleep do you average a night? Have there been any recent changes? Is this sleepful rest?

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

_____

_____

When did your problem begin? Please specify a date if possible:_____

_____

Please describe any significant events occurring at that time: _____

_____

Have you had counseling previously? YES NO

If yes, give the date, counselor's name, and how you believe this benefited you._____

_____

_____

Permission to contact your previous counselor? YES NO