



FIRST COUNSELING

BIBLICAL COUNSELING OF FIRST BAPTIST CHURCH JACKSONVILLE

Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____ Zip Code: _____

Age: _____ Gender: _____ Referred By: _____

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

Education (highest level completed): _____

Preferred Phone: _____ Is this home, cell, or work? _____

Email: _____

Employer: _____ Position: _____

Years: _____

Marriage and Family

Spouse: _____ Birth Date: _____

Age: _____ Occupation: _____ How Long Employed: _____

Preferred Phone: _____ Is this home, cell, or work? _____

Date of Marriage: _____ Length of Dating: _____

Give a brief statement of circumstances of meeting and dating: _____

Have either of you been previously married: _____ To whom: _____

Have you ever been separated: _____ Filed for divorce: _____

Is your spouse willing to come for counseling: _____

Is your spouse in favor of your coming: _____ If no, please explain:

Information about Children:

Name: Age: Gender: Living: Year Ed.: Step-Child:

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? _____

Health

Describe your 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 contact information:

Current medication(s) and dosage:

Have you ever-used drugs for anything other than medical purposes? _____

If yes, please explain:

Have you ever been arrested? _____

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 cigarettes or use tobacco products? _____ Frequency: _____

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

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

Have you ever seen a psychiatrist or counselor? _____ If yes, please 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 ever been baptized? _____

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

Explain any recent changes in your religious life:

Financial

Approximate yearly family income: _____

Do you own your home? _____ yes _____ no

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

_____ home _____ car _____ school _____ credit cards

Are you saving money? _____ yes _____ no

Do you give money to your church or other charities? _____ yes _____ no

Is money a source of struggle or discomfort in your life? _____ yes _____ no

Are you involved in or anticipate being involved in legal actions? _____ yes _____ no

Women Only

Have you had any menstrual difficulties? _____ If you experience tension, tendency to cry, other symptoms prior to your cycle, please explain: _____

YOUR INFORMATION

We are grateful to the LORD for the opportunity to meet with you and sincerely desire to understand what is happening in your life. The below checklist and questions are a way for us to gather more information about what is going on. You can check as many boxes as you need, and your answers can be as long as you like, but please write at least a few sentences for each question. **(If additional space is needed, please feel free to answer the questions in a separate document.)** Thank you for your help, and we will be prayerfully anticipating our meeting.

Problem Check List

- | | | |
|--|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Drunkenness | <input type="checkbox"/> Loss of Loved One |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Lust |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Envy | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Fear | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Finances | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Change in lifestyle | <input type="checkbox"/> Gluttony | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Children | <input type="checkbox"/> Guilt | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Health | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Conflict (fights) | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Deception | <input type="checkbox"/> Impotence | <input type="checkbox"/> Spousal Abuse |
| <input type="checkbox"/> Decision Making | <input type="checkbox"/> In-laws | <input type="checkbox"/> A Vice |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Other |

Please Tell Us Your "STOREE."

*It will be helpful to have at least a few sentences or short paragraph for each letter of STOREE.
(If additional space is needed, please feel free to answer the questions 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?

Desires/Expectations: How do you hope we can help you? What do you want the most related to this situation?

Is there anything else we should know?