

Whitesburg Baptist Biblical Ministry

Personal Data Inventory

I. Contact Information

Name: _____ Date: _____
Email Address: _____ Home: _____
Gender: _____ Birth Date/Age: _____ Work: _____
Employer/Occupation: _____ Cell: _____

List the people who currently live in your household:

Emergency Phone Number: _____ Only used in case of emergency.

II. Spiritual History:

What church do you currently attend: _____

Pastor's name; _____

Church attendance per month: _____

Do you believe in God? Yes _____ No _____ Uncertain _____

Are you a Christian? Yes _____ No _____ Becoming One _____

Have you been baptized? Yes _____ No _____ When? _____

Describe your salvation experience:

Describe your relationship with Jesus Christ now:

How often do you read the Bible? Never _____ Occasionally _____ Regularly _____

Do you have personal devotions? Never _____ Occasionally _____ Regularly _____

Describe your personal devotions:

Do you have family devotions? Never _____ Occasionally _____ Regularly _____

Describe your family devotions:

Explain any recent changes in your spiritual life:

III. Personal History:

Briefly describe your life.

Early Childhood:

Adolescence 10-17:

Marital Status:

Single _____

Dating/Engaged _____

Married _____

Separated _____

Divorced _____

Widowed _____

Complete if dating or engaged:

Date you met: _____

Length of dating: _____

Are you planning to marry? _____

Expected date of wedding? _____

Complete if you are married:

Length of steady dating with spouse: _____

Date of marriage _____

Length of engagement: _____

Ages at time of marriage: Husband _____ Wife _____

Briefly describe your relationship:

Is your spouse willing to come to counseling? Yes _____ No _____

Children's Names	Age	Gender	Living at home	Education (in years)	Marital Status (*PM)
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*Check this if child is y previous marriage.

IV. Medical History:

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

Date of last medical examination: _____ Report: _____

Your physician: _____ Address _____

Are you taking any medications currently? Yes _____ No _____ If yes, please answer below:

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any current medical condition or history pertinent to problem:

Have you received any therapy, psychotherapy, counseling, or treatment in the past year? Yes _____ No _____

If yes, when? _____ With whom? _____

How often? _____ Reason(s) _____

V. Current Personal Information:

Do you consume alcohol? _____ How often? _____ How much? _____

Have you ever used drugs for non-medical purposes? _____

If yes, please explain: _____

Have you ever been arrested? _____

If yes, please explain: _____

What is your average daily caffeine consumption? Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks.

Sleep Patterns (Answer YES or NO):

Do you have trouble falling to sleep? _____ Do you have difficulty staying asleep? _____

Do you awaken frequently in the night? _____ Do you generally nap during the day? _____

Do you use sleep medications? _____ Do you feel rested when you awaken? _____

Do you have sleep apnea? _____

On average, what time do you go to bed? _____ Wake up _____

Are your weekend sleep pattern different from weekdays?

Explain: _____

Please note the average number of times per week spent on each of the following activities:

Cleaning _____	Movies _____	Television _____
Computer _____	Reading _____	Social Networking _____
Gaming _____	Shopping _____	Texting/Cell Phone _____
Grooming _____	Sports _____	
Hobbies _____	Work _____	

Please **mark** any symptoms that you have had in the past **six months**:

Change in appetite

- Low motivation
- Fatigue/low energy
- Depressed mood/sadness
- Anxiety/fear
- Panic

- Problems concentrating
- Isolating from others
- Frequent anger
- Tearful/crying spells
- Hopelessness
- Other

Please **mark** any of the following that best describe you **now**:

- | | | | | | |
|-------------------------------------|------------------------------------|---|---------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Fearful | <input type="checkbox"/> Bitter | <input type="checkbox"/> Good natured | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Impatient |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Ambitious | <input type="checkbox"/> Self-confident | <input type="checkbox"/> Shy | <input type="checkbox"/> Moody | <input type="checkbox"/> Distracted |
| <input type="checkbox"/> Kind | <input type="checkbox"/> Nervous | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Serious | <input type="checkbox"/> Suspicious |
| <input type="checkbox"/> Introvert | <input type="checkbox"/> Excitable | <input type="checkbox"/> Hardworking | <input type="checkbox"/> Frustrated | <input type="checkbox"/> Leader | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Extrovert | <input type="checkbox"/> Likable | <input type="checkbox"/> Imaginative | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Rebellious | <input type="checkbox"/> Cynical |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Lonely | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Submissive | <input type="checkbox"/> Calm | <input type="checkbox"/> Other |

Have you ever had a severe emotional upset (YES or NO) _____

If yes, please explain:

Have you attempted suicide? Do you currently struggle with suicidal thoughts? (YES or NO) _____

If yes, please explain:

Have you had or have an eating disorder? (YES or NO) _____

If yes, please describe:

Please mark all issues that apply:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Deception | <input type="checkbox"/> Grief | <input type="checkbox"/> Perfection |
| <input type="checkbox"/> Adultery | <input type="checkbox"/> Decision Making | <input type="checkbox"/> Health | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Depression | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drunkenness | <input type="checkbox"/> In-Laws | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Envy | <input type="checkbox"/> Impotence | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Fear | <input type="checkbox"/> Lifestyle Change | <input type="checkbox"/> Spouse Abuse |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Finances | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Children | <input type="checkbox"/> Fornication | <input type="checkbox"/> Lust | |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Gambling | <input type="checkbox"/> Memory | |
| <input type="checkbox"/> Conflict (fights) | <input type="checkbox"/> Gluttony | <input type="checkbox"/> Moodiness | |

1. What circumstances/issues led to your request for Biblical Counseling at this point in time?

When did this begin? Please specify a date if possible.

Please describe any other significant events occurring at that time.

2. How have you tried to resolve these issues?

3. What are your goals for counseling?

4. Is there any other information we should know?
