



Biblical Counseling

PERSONAL DATA INVENTORY

Please complete this form carefully and thoroughly. Return upon completion by e-mail: counseling@thekiln.org

PERSONAL IDENTIFICATION

Name _____

Birth Date _____

Address _____

Age _____ Sex _____ Referred by _____

E-mail _____

Marital Status: Single Engaged Married Separated Divorced
 Widow

Home Phone _____ Cell _____

Occupation _____ Employer _____

Years _____ Education (last yr. completed) _____

Education Institution(s)

MARRIAGE & FAMILY

Spouse

Name _____ Birth Date _____

Home Phone _____ Occupation _____

Date of Marriage _____

How long did you know your spouse before marriage? _____



How did you meet?

Have either of you been previously married? (please explain)

Have you ever been separated? _____ (please provide date)

Have you ever filed for divorce? _____

Children

Name	Age	Sex	Living?	Step-Child?

Parents and Siblings

Describe your relationship with your father:

Describe your relationship with your mother:

Number of brothers and sisters _____ Your birth order _____

Did you live with anyone other than your parents growing up?



Are your parents still living? _____ Do they live locally? _____

HEALTH

Describe your health. How do you feel physically?

Do you have any chronic medical conditions?

Please list any and all important illnesses, injuries or handicaps

What is the date of your last medical exam? _____

Physician's name and name of practice:

List any current medication(s), including dosage

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

If yes, please explain:

Have you ever been arrested? _____ (yes/no) If yes, please explain:

Do you drink alcoholic beverages? _____ (yes/no) If so, how frequently and how much? _____

Do you drink coffee? _____ (yes/no) How much? _____

Other caffeine drinks: _____

How much? _____

Do you smoke? _____ How often? _____



Have you ever had interpersonal problems on the job? _____

If yes, please explain: _____

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

SPIRITUAL

Denominational preference:

Current Church:

Are you a Member? _____ (yes/no)

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

Do you believe in God? _____ (yes/no)

Do you pray? _____ (yes/no)

Do you consider yourself a Christian? _____ (yes/no)

Have you been baptized? _____ (yes/no)

If yes, how old were you? _____

How often do you read the Bible?

Never _____ Occasionally _____ Often _____ Daily _____

Have there been any recent changes in your spiritual life?



ISSUE CHECKLIST

Please check the issues you are experiencing:

Anger _____ Depression _____ Loneliness _____ Anxiety (worry) _____
Drunkenness _____ Lust _____ Apathy _____ Envy _____ Memory _____
Appetite _____ Fear _____ Moodiness _____ Bitterness _____ Finances _____
Perfectionism _____ Change in lifestyle _____ Gluttony _____ Rebellion _____
Children _____ Guilt _____ Sex _____ Communication _____ Health _____
Sleep _____ Conflict (fights) _____ Homosexuality _____ Wife Abuse _____
Deception _____ Impotence _____ A Vice _____
Decision-making _____ In-laws _____

Please answer the following questions:

1. What brings you here?

2. What have you done so far about this issue?



3. What are your expectations from counseling?

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



WOMEN ONLY

Have you had any menstrual difficulties? _____ (yes/no)

Do you experience tension, tendency to cry, other symptoms prior to your cycle?
_____ (yes/no)

Please explain:

Is your husband willing to come for counseling?

Is he in favor of your coming? _____ (yes/no)

If no, please explain:
