COUNSELING WITH A BIBLICAL PERSPECTIVE
P.O. Box 1016
Flint, Texas 75762-9703

PERSONAL DATA INVENTORY (PDI)

To allow us to be more efficient at helping, we ask you to please complete this form before your initial appointment and bring it to your initial appointment thusly giving us a more comprehensive picture of you allowing our sessions to be more productive. All information contained in this form is confidential and allows your counselor to have the information so he can be prepared to provide you the best possible service.

Date:
Your Full Name:

SECTION I -- OCCUPATIONAL STATUS/HISTORY	
Your Education *(Highest level completed)*	School/Institute:
Currently Employed: YES NO	
If **NO** how long unemployed?	
Current Occupation:	Name of Company:
City/State:	
# Years there:	Work Telephone ( )
Does your present work satisfy you? YES NO	(Please explain):
What other job positions have you held in the past?	
Spouse's Education *(Highest level completed)*	School/Institute:
Currently Employed: YES NO	If **NO** How Long?
Occupation:	Name of Company:
City/State:	
# Years there:	Work Telephone ( )

Estimated Household Gross Income: (Please circle one)			under $10,000	10,001-12,000
12,001 – 15,000	15,001 – 20,000	20,001 – 25,000	25,001 – 30,000	30,001 – 35,000
35,001 – 40,000	40,001 – 45,000	45,001 – 50,000	50,001 – 55,000	55,001 – 60,000
60,001 – 65,000	65,001 – 70,000	70,001 – 75,000	75,001 – 80,000	80,001 – 85,000
85,001 – 90,000	90,001 – 95,000	95,001 – 100,000	$100,000+	

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SECTION II -- MARITAL STATUS/HISTORY (Fill as applicable)			
Current Status (circle): Single Engaged Cohabitating Married Separated Divorced Widowed			
Engaged to:	Planned Wedding Date:		
Cohabitating Partner:			
Present Marriage: *(if applicable):*			
Spouse's name:		Age:	
Date of current marriage:	Place:	Years married:	
Rate your current marriage (circle: 0 as terrible, 5 as excellent): 0 1 2 3 4 5			
Separated; (dates and circumstances)			
Previous Marriage(s): *(if applicable): Number of marriages:*			
Date of marriage:	Date of Divorce:		
Date of Marriage:	Date of Divorce:		
Widowed/Widower: Date of loss:			
What might make your current marriage better?			
Children *(if applicable):*			
Name	Son/Daughter	Age	Where They Live
Previous Marriages (if applicable): Number: ( )			
Name of Spouse:		Length of marriage:	
Children			
Name	Son/Daughter	Age	Where They Live

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Name of Spouse:			Length of marriage:	
Children:				
Name	Son/Daughter	Age	Where They Live	
Has your current spouse been previously married?			YES	NO
If YES, how many times?				
Children:				
Name	Son/daughter	Age	Where They Live	

SECTION III -- FAMILY OF ORIGIN HISTORY

Parents:	Name (First)	Age	Where Live	Marital Status	Occupation
Father:					
Mother:					
Guardian:		Relation to you:		Dates:	

Brothers/Sisters: (List in order from oldest to youngest; include yourself in that order):

Name (First)	Bro/Sis/Step	Age	Where They Live	Marital Status	Occupation
1					
2					
3					
4					
5					

Family "Climate": Describe your home life during your childhood and teen years:

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Indicate any problems you experienced as a child or teen:

Family problems___ School problems___ Emotional/behavior problems___ Legal problems___ Medical problems___ Social problems___ Drug/alcohol problems___

Other:

Psychological Problems: Have you, or any parent or brother or sister, been hospitalized or received professional help for "psychological" problems? Specify person, dates and problem.

SECTION IV -- RELIGIOUS STATUS/HISTORY

Church Presently Attending: City & State:

Member: Yes No Average # of times per month you attend:

Pastors Name: Telephone: ( )

Do we have permission to contact/discuss you counseling with him/her?: Yes No

Do you believe in God? Yes - No - Unsure

Do you consider yourself "saved?" Yes No Unsure Don't understand the term.

How frequently do you pray? Frequently Occasionally Rarely Never

How frequently do you read the Bible? Often Occasionally - Rarely Never

What is your view of the Bible?

Have you come to the place in your spiritual life where you know for certain that if you were to die today you would go to heaven? Yes No Unsure

Why do you want to receive *Pastoral/Biblical* counseling?

Explain any recent changes in your religious life:

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SECTION V -- MEDICAL STATUS/HISTORY

Rate your current health: Very Good Good Average; Poor

Any Recent Health Problems?

Any Recent Surgery?

Date of last medical exam:

Report:

Your Primary Care Physician:

City & State: Phone #:

Do we have your permission to contact him/her? YES NO

Please list all prescription medications you take:

Medication	*Treatment for*	*When began*	*Daily dosage*	*Prescribing Physician*

Please List all over-the-counter medications you currently take (diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, etc.):

List any surgeries which required anesthesia:

Average daily caffeine consumption? *(Coffee, tea, chocolate, stimulants, caffeinated soft drinks, etc.)*

Number of cups/cans/bottles:

How often do you drink alcoholic beverages? *(Please Circle One)*

Often – Occasionally - Rarely - Never

Have you ever used any type of illegal drugs? *(Please Circle One)*

YES NO

How often do you struggle with the temptation to use illegal drugs?

Often – Occasionally – Rarely – Never

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Average number of hours of sleep each night ( )
Is it restful? YES – NO
Describe any recent changes in your sleep patterns:

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

	Heart problems		Seizures		Thyroid dysfunction
	Hypoglycemia		Anorexia or Bulimia		Nausea or vomiting
	Menstrual irregularities		Multiple sclerosis		Dizziness
	Liver problems		Sensory distortions		Diabetes
	Lung problems		Episodic disorientation		Recent weight change
	Hallucinations		Parkinson's disease		Stiff neck
	Kidney problems		Weakness		High Blood pressure
	Allergies		Fatigue		Impotence
	Change in sexual drive		Deja Vu		Physical changes
	Head injury/concussion		Amnesia		Constant hunger
	Cancer		Heat/cold sensitivity		Food cravings
	Problems walking		Changes in consciousness		Fever
	Stroke		Tremors		Pneumonia
	In-coordination		Bowel/bladder problems		Speech problems
	Unusual hair loss		Headaches		Brain tumor
	Personality change		Rashes		Memory problems
	Blackouts		Visual problems		

Have you or others noticed any changes in your personality (anger, mood swings, and withdrawal), your thinking and memory, or your work habits? YES - NO
If YES please describe.

SECTION VI – LEGAL ACTIONS (if applicable, e.g., in Conflict or Separation/Divorce Cases)	
If you have talked with an attorney about your problem, or intend to, please provide the following:	
Attorney:	Firm:
Address:	Phone: ( )
Date and purpose:	

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Has a legal action been filed or is one likely to be filed in this situation? No – Yes
(If yes, give dates and describe action below.)

Have you received advice from anyone else regarding this situation? No - Yes
(If yes, give names and dates below.)

SECTION VII - Military Service

Army Navy Marine Corps Air Force Coast Guard

Length of Service: Combat? YES NO

Highest Rank: Military Occupation?

Service Location(s):

Are any of your counseling concerns related to your military service? YES NO
(If YES please explain)

SECTION VIII - ADDITIONAL INFORMATION THAT MIGHT BE HELPFUL FOR US TO KNOW ABOUT YOU:

By submitting this completed form I affirm that the above information is true and correct to the best of my knowledge.

Name: *(Print)* ______________________________

Sign: ______________________________

Date: ______________________

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