The Bridge Counseling Center

Personal Data Inventory

PERSONAL IDENTIFICATION

Name: _____ Referred by: _____

Address:_____ Zip Code: _____

Email: _____

Phone: Home_____ Work: _____ Cell: _____

Sex: Birth Date: _____ Age: ____

Marital Status: Education (last year completed): _____

Employer: _____ Position: _____ Years: _____

MARRIAGE AND FAMILY

Spouse: _____ Birth Date: _____ Age:_____

Occupation: _____ How Long Employed: _____

Phone: Home _____ Work: _____ Cell: _____

Date of Marriage: _____ Length of Dating: _____

Give a brief statement of circumstances of meeting and dating:

Have either of you been previously married? If yes, to whom: _____

Have you ever (check all that apply): ☐ been separated? ☐ filed for divorce?

Children:

Name:	Age:	Sex:	Living:	Year Education	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? If yes, with whom? _____

Are your parents living? Do they live locally?

HEALTH

Describe your health: _____

Do you have any chronic conditions? If so, what: _____

List important illnesses and injuries or handicaps: _____

Date of last medical exam: _____ Report: _____

Physician's name and address: _____

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...?	How often?	How much?
Alcoholic beverages		
Coffee		
Other caffeine drinks		

Do you smoke? What: _____ Frequency: _____

Have you ever (check all that apply):
☐ had interpersonal problems on the job?
☐ had a severe emotional upset?
☐ seen a psychiatrist or counselor?

If yes, please explain:

SPIRITUAL

Do you believe in God?
I am:
How often do you read the Bible?

Do you pray?
Have you ever been baptized?
Church attendance per month?

Denominational preference? _____

What church do you attend?_____ Member?

Explain any recent changes in your religious life:

WOMEN ONLY

Have you had any menstrual difficulties?

If you experience tension, tendency to cry, other symptoms prior to your cycle, please explain:

Is your husband willing to come for counseling?

Is he in favor of your coming?

If no, please explain:

PROBLEM CHECK LIST (check all that apply)

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

If other, please specify: _____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS

What is your problem (what brings you here)?

What have you done about the problem?

What are your expectations from counseling?

Is there any other information that we should know?

SCHEDULING

When are you generally available for counseling? (check all that apply). A counselor will contact you to set up a specific time, taking into account the information you provide below.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning (9am-noon)		☐	☐	☐	☐	☐	☐
Afternoon (12-6pm)	☐	☐	☐	☐	☐	☐	☐
Evening (6-9pm)	☐	☐	☐	☐	☐	☐	☐