

Restored Hope Biblical Counseling

PERSONAL DATA INVENTORY

Date

Please be aware that there are no wrong or right answers to the following questions but the answers will help us to know and serve you better.

PERSONAL INFO

Name:	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Age
Email:	Date of Birth:	
Best phone number to reach you: ()		
Address:		
Education (last year completed):		
Current Occupation (or responsibility):		
How many hours do you work in a week at your job?		

Who do you live with (their relationship to you)? _____

Help us get to know you. Mark on each continuum line below how you would describe yourself, generally.

More _____	More _____	More _____	More _____
Analytical	Creative	Energetic	Calm/Sedate
More _____	More _____	More of a _____	More of a _____
Out-going	Shy	Leader	Follower
More _____	More _____	More of an _____	Harder to
Easy-going	Serious	Open Book	get to Know
More _____	More _____	More _____	More _____
Decisive	Unsure	Confident	Nervous
More _____	More _____	More often _____	More often _____
Introverted	Extraverted	Happy	Sad
More _____	More _____	More _____	More _____
Dependable	Forgetful	Sensitive	Direct/Blunt
More of a _____	More of a _____	More _____	More _____
hard-worker	Procrastinator	Moody	Even-Tempered
More _____	More _____	More _____	More in my
Logical	Feeling led	Others-minded	own World
More of a _____	More of a _____	More _____	More _____
Fixer	worrier	\Self-Conscious	Care-free

More _____
Organized _____
More _____
Independent _____
More Slow _____
to Act _____
More _____
Go w/the _____
Flow _____

More _____
Haphazard _____
More _____
Reliant _____
More _____
Impulsive _____
more _____
Controlling _____

More _____
Cautious _____
More _____
Gracious _____
More _____
Patient _____
More People _____
Oriented _____

More _____
Spontaneous _____
More _____
Critical _____
More _____
Impatient _____
More Project _____
Oriented _____

Are you in a significant relationship other than marriage? Explain and include how long:

MARRIAGE AND FAMILY INFO

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Spouse's Name:	Length of Marriage:
Spouse's Current Occupation (or responsibility):	Weekly Hours:

Age	Sex	Living?	Are they Marriage?	By Previous Children's Names:

Have you ever been separated before? ☐ Yes ☐ No

If yes, please explain: _____

Has either of you ever considered or filed for divorce? ☐ Yes ☐ No

If yes, please explain: _____

Have you been married before? ☐ Yes ☐ No

If yes, please explain: _____

Is your spouse in favor of your coming to counseling? ☐ Yes ☐ No

Is your spouse willing to come to counseling (if needed)? ☐ Yes ☐ No

HEALTH INFO

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

Date of last medical exam: _____ Report: _____

Physician's name: _____ Address: _____

List all prescriptions and over-the counter medications you are currently taking (Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, etc.). *Continue on back as needed

Med: _____ For What? _____

Med: _____ For What? _____

Med: _____ For What? _____

Med: _____ For What? _____

List all important present or past illnesses, physical difficulties, injuries or handicaps: _____

Do you have any chronic medical conditions? _____

Have you used drugs for other than prescribed medical purposes? ☐ Yes (Past) ☐ Yes (Now) ☐ No

What Drug? _____ How Long? _____

Have you used more than the prescribed amount of any medication? ☐ Yes (Past) ☐ Yes (Now) ☐ No

What Drug? _____ Amount: _____ How Long? _____

How much of the following type of beverages do you consume daily or weekly?

Alcohol _____ Coffee _____ Tea _____ Soft Drink _____ Water _____

On a scale of 1-10, how healthy do you eat? _____ Do you smoke? ☐ Yes ☐ No

How often do you exercise? _____ Times/Week ☐ Rarely ☐ Never

How many hours of sleep do you average each night? _____

Has there been any recent change? _____

Is this sleep uninterrupted? _____

Have you ever experienced hallucinations, seen distorted faces, or heard voices? ☐ Yes ☐ No

If yes, please explain: _____

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

Have others noticed any significant changes in your emotional or mental state, memory, or work abilities?

Are you willing to sign a release of information so that your counselor may write for any counseling and medical information that might be helpful? ☐ Yes ☐ No

BACKGROUND INFO

Please answer these background questions to the best of your ability, so we might minister to you more sensitively and wisely. These questions are **not** meant to imply: 1) that we cannot now know God as sovereign, good and sufficient regardless of our past, 2) that God cannot use our past for good, 3) that our past is our identity nor, 4) that we will/must be determined by our past.

Were you raised by both biological parents? ☐ Yes ☐ No

If no, please explain: _____

Rate your parent's marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Are/were your parents divorced? ☐ Yes ☐ No Explain briefly when, and the basic circumstances:

Describe your relationship with your mother: _____

Describe your relationships with your father: _____

How many older siblings do you have? Brothers _____ Sisters _____

How many younger siblings do you have? Brothers _____ Sisters _____

Describe your relationships with your siblings: _____

Check all the following that best describe the parenting style of your childhood (M=Mother, F=Father):

Excessively authoritative/ Very high control	___ M ___ F	Rules/Instructions without relationship	___ M ___ F
Excessively permissive/ Too low control	___ M ___ F	Disengaged/ Excessively preoccupied	___ M ___ F
Generally balanced leadership/Authority	___ M ___ F	Caring involvement/ Instruction	___ M ___ F
Manipulative (selfish, angry, guilt trip)	___ M ___ F	Perfectionistic/very performance driven	___ M ___ F
Leading by example	___ M ___ F		

Check all the following that best describe the predominant atmosphere(s) in your home as a child:

<input type="checkbox"/> Happy	<input type="checkbox"/> Secure/Safe	<input type="checkbox"/> Open/Honest	<input type="checkbox"/> Truly Christian
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/> Sad/Depressing	<input type="checkbox"/> Tumultuous/ Outwardly-religious	<input type="checkbox"/> Closed off/Private
<input type="checkbox"/> Calm/Relaxed	<input type="checkbox"/> Angry/Hostile	<input type="checkbox"/> Loving/Encouraging	<input type="checkbox"/> Non-Christian

Was there any substance abuse in your family? ☐ Yes ☐ No

If yes, please explain: _____

Other and Later Life:

Other than your parent(s), describe people in your life who have had a significant influence in your life (positive or negative): _____

Has there been any abuse in your past? ☐ Physical ☐ Verbal/Emotional ☐ Sexual ☐ No

If yes, by whom? _____ What age? _____

Have you ever seen a psychologist, psychiatrist or received counseling before? ☐ Yes ☐ No

If yes, list counselor(s): _____ and dates ____ / ____ / ____ to ____ / ____ / ____
_____ and dates ____ / ____ / ____ to ____ / ____ / ____
_____ and dates ____ / ____ / ____ to ____ / ____ / ____

What were you seen for? _____

What was the outcome? Was it helpful? _____

☐ Yes ☐

Do you carry significant guilt? No

If yes, for what? _____

Any job difficulties? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been arrested? ☐ Yes ☐ No When? _____

Describe the circumstances: _____

Describe any recent, significant event(s) in your life (i.e. job loss, birth, death, successes, etc.):

SPIRITUAL LIFE INFO

Church/religious experience as a child (Denomination and length of time): _____

Church/religious experience as an adult (Denomination and length of time): _____

Do you attend a local Christian church? ☐ Yes ☐ No

Name of the church you attend: _____

Are you a member? ☐ Yes ☐ No How long? _____

Have you been baptized? ☐ Yes ☐ No At what age? _____

Church services/functions attended per month: _____

Are you part of a Small Group: ☐ Yes ☐ No Who is your Small Group leader: _____

Do you attend church with your spouse? ☐ Yes ☐ No

If no, please explain: _____

Do you consider yourself as "saved"? ☐ Yes ☐ No ☐ Not sure what you mean

Does your spouse consider himself/herself as “saved”? ☐ Yes ☐ No ☐ Don't know

Have you come to the place in your spiritual life where you know with certainty that you would enter heaven after death? ☐ Yes ☐ No

If you were to die and stand before God and He asked you why He should permit you to enter heaven, how might you respond? _____

Explain recent changes in your spiritual life, if any: _____

How often do you pray to God? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

How often do you read the Bible? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Do you regularly give financially to the church/God's work? ☐ Yes ☐ No

Do you serve at your church? How? _____

PROBLEM CHECK LIST

Please mark 1-3 on all that apply (1=Mild, 2=Moderate, 3=Severe). Circle where there are options.

- | | | |
|--|----------------------|-------------------------|
| ___ Abuse at present
(sexual, Physical, verbal) | ___ Drunkenness | ___ Memory |
| ___ Anger | ___ Drugs | ___ Mental confusion |
| ___ Anorexia | ___ Envy or jealousy | ___ Moodiness |
| ___ Anxiety | ___ Fear | ___ Overwhelmed |
| ___ Apathy | ___ Finances | ___ Perfectionism |
| ___ Bitterness | ___ Gambling | ___ Poor concentration |
| ___ Bulimia | ___ Gluttony | ___ Pornography |
| ___ Children | ___ Guilt | ___ Procrastination |
| ___ Communication | ___ Grief | ___ Rebellion |
| ___ Conflict (Fights) | ___ Health | ___ Same sex attraction |
| ___ Deception | ___ Homosexuality | ___ Self-injury |

_____ Decision making

_____ Infidelity

_____ Sex (lust, impotence...)

_____ Depression

_____ In-laws

_____ Sleep

_____ Drastic change in life
circumstances/life style

_____ Loneliness

_____ Other

PRE-COUNSELING QUESTIONS

Please take some time to think through what has been happening in your life that brings you to counseling. This section will help us get to know your current situation better, Use the following questions as a guide to journal about what is going on in your life and heart.to provide the best help.

1. What has brought you here? Describe the main problem in your life as you see it. (Include when it began and any other very significant events or information.)

2. What have you done to try and resolve the problem on your own?

3. Why are you now wanting to seek help?

4. What types of thoughts come to your mind in your current situation when you feel disappointed, discouraged, angry and/or fearful about the situation?

5. What are you hoping we can do for you?

6. Is there any other information you think we should know?

SCHEDULING

Please check the time and days that you are available for counseling.

	SUN	MON	TUE	WED	THU	FRI	SAT
Early morning (6am-9am)							
Morning (9am-12pm)							
Early afternoon (12pm-3pm)							

Afternoon (3pm-6pm)							
Evening (6pm-9pm)							

Do you have flexibility with your schedule? ☐ Yes, on these days _____ ☐ No