PERSONAL DATA INVENTORY

INSTRUCTIONS: This confidential information is needed to begin counseling.

DATE:_____

IDENTIFICATION DATA:

Name:_____ Birth date:_____

Address:_____City:_____State: _____Zip:_____

Home Phone:_____Cell:_____Work:_____

Email: _____

Occupation:_____Employer:_____

If under 18, name of parent or guardian:_____

If student, name of school:_____

Education completed:_____

Other training (list type & years):_____

Military History: List branch of service and years_____

Served in Combat?_____

RELATIONSHIP INFORMATION:

Marital Status: Single (Never married)_____Going steady_____Engaged_____Married (1st time)____

Remarried_____Single (Divorced)_____Separated_____Living with Partner_____

Name of spouse/partner_____

Spouse/Partner's age_____Education (in years)_____Occupation_____

Employer_____Is partner willing to come to therapy?_____

Number of years together: _____

Please give information about previous marriages. Include date of marriage, date of dissolution,

whether it ended in divorce or death, and state of any ongoing contact:_____

_____

_____

_____

_____

INFORMATION ABOUT FAMILY:

List your biological children (names and ages):_____

_____

List your children: step (SC), adopted (AD), or foster (FS) with names and ages:_____

_____

Were you reared by your biological parents?_____ Yes_____ No, please explain_____

RELIGIOUS BACKGROUND:

Do you consider yourself a religious person? Yes_____ No_____ Uncertain_____

Church/Synagogue/Mosque attending_____

Minister/Priest/Rabbi/Imam_____

Do you consider yourself a spiritual person? Yes_____ No_____ Uncertain_____

If yes, list current spiritual practices: _____

HEALTH INFORMATION: Check and comment about the following as they apply to you.

_____Current/chronic medical conditions_____

_____Recent weight changes: Lost_____ Gained_____

_____Serious illnesses/injuries/traumas_____

_____Hospitalizations or surgeries_____

_____Current sleep patterns_____

_____Exercise Habits_____

List current medications and dosages_____

_____

Your physician (name)_____Phone:_____

Have you ever had counseling before? No_____ Yes____ When?_____

Number of sessions_____ For what purpose_____

Counselor or Therapist_____Phone:_____

Comments about previous counseling experiences:_____

_____

FOR TREATMENT PLANNING:

Type of counseling desired: Individual_____ Pre-Marital_____ w/Spouse_____

w/Primary Relationship _____Family_____

What is the concern that motivated you to seek therapy?_____

_____

_____

For those areas that apply to you, please rate your distress level:
0-None 1-Very Little 2-Little 3-Moderate 4-Considerable 5-Very Considerable 6-Maximum

_____Depression
_____Suicidal thoughts
_____Suicidal actions
_____Anxiety
_____Panic Attacks
_____Sleep Problems
_____Eating disorder
_____Withdrawn behavior
_____Health problems
_____Job related problems
_____Financial concerns
_____Domestic violence
_____Parent-child conflict (self)
_____Parent-child conflict (other)
_____Communication problems
_____Other_____

_____Alcohol/other drug use (self)
_____Alcohol/other drug use (family)
_____Marital/relationship problems
_____Sexual problems
_____Physical abuse
_____Legal difficulties
_____Death of a loved one
_____Compulsive gambling
_____Self-esteem
_____Career choice concerns
_____Sexual abuse, actual
_____Sexual abuse, threatened
_____Brother/sister problems
_____Blended family issues
_____Parental loss of control
_____Spiritual health

What Goals do you hope to accomplish in therapy?_____

_____

_____

REFERRAL:

Referred by_____Relationship_____

ADDTIONAL INFORMATION:

Is there additional information that has not been covered on this form that you think is critical to

your current situation?_____

_____

_____

_____