The Bridge Counseling Center

Personal Data Inventory

Personal Identification

Name: ____ Birth Date: __________________________

Address: ____ Zip Code: _____________

Age: ________ Sex: _____________ Referred By: _______________________________________

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

Education (last year completed): ____

Home Phone: ______________ Work Phone: _______________ Cell Phone: __________________

Email:____

Employer: __________________________________ Position: ___________________Years: _____

Marriage and Family

Spouse: _______________________________________ Birth Date: __________________________

Age: _________ Occupation: _____________________ How Long Employed: ________________

Home Phone: ______________ Work Phone: _______________ Cell Phone: _________________

Date of Marriage: __________________________ Length of Dating: __________________________

Give a brief statement of circumstances of meeting and dating: _______________________________

____

Have either of you been previously married? _________ To Whom: ___________________________

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

Information about Children:
Name: Age: Sex: Living: Year Ed.: 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? _______________________________________

Are your parents living? _________ Do they live locally? ____________________________

Health

Describe your health: ____

Do you have any chronic conditions? ________ 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? ☐ Yes ☐ No

If yes, please explain: ____

Have you ever been arrested? ☐ Yes ☐ No

	Do you drink...?		How often?	How much?
Alcoholic beverages	☐ Yes	☐ No		
Coffee	☐ Yes	☐ No		
Other caffeine drinks	☐ Yes	☐ No		

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

Denominational preference? ____

Church attending? _______________________________________ Member? ___________________

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

Do you believe in God? ☐ Yes ☐ No Do you pray? ☐ Yes ☐ No

Are you (check one): ☐ A Christian? ☐ Still in the process of becoming a Christian?

Have you ever been baptized? ☐ Yes ☐ No

How often do you read the Bible? ☐ Never ☐ Occasionally ☐ Often ☐ Daily

Explain any recent changes in your religious life: ____

Women Only

Have you had any menstrual difficulties? ☐ Yes ☐ No

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

____

Is your husband willing to come for counseling? ☐ Yes ☐ No

Is he in favor of your coming? ☐ Yes ☐ No

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?