GOOD HOPE
MISSIONARY BAPTIST CHURCH

3015 MacGregor Way
Houston, TX 77004
Office (713) 524-6578

BIBLICAL COUNSELING MINISTRY

PERSONAL DATA INVENTORY

Please complete this inventory carefully

(Question marks have been omitted)

Personal Identification:

Name _____ Date of Birth _____

Address _____

Home Phone _____ Business Phone _____

Cellular Phone _____ Email Address _____

Age _____ Sex _____ Referred By _____

Marital Status:

Single____ Engaged_____ Married_____ Separated _____ Divorced_____Widowed_____

Education: (last year completed) _____

Employer _____

Position _____ Years Employed _____

In case of an emergency, please contact _____

Relationship _____ Contact Number _____

Marriage and Family:

Spouse _____ Date of Birth _____

Age _____ Occupation _____ How long employed _____

Date of Marriage _____ Length of Dating _____

Is your spouse willing to come for counseling _____ Is he/she in favor of your coming for counseling _____

Give brief statement of circumstances of meeting and dating _____

_____

_____

Have either of you been previously married _____ Did you file for divorce _____

Have you ever been separated _____

How many pregnancies have you had _____ How many live births _____

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Information about your children:

Name	Age	Sex	Living (Y / N)	Yrs of Edu.	Step-child

Describe your relationship with your father _____

Describe your relationship with your mother _____

Number of siblings _____ **Your sibling order** _____

Do you live with anyone other than your parents _____

Are your parents living Yes No Do they live locally Yes No

Health:

Describe your health _____

Do you have any chronic conditions _____ Describe _____

List important illnesses/injuries/handicaps _____

_____

Date of last medical exam _____ Report _____

Physician's name and address _____

_____

Current medication(s) and dosage _____

_____

Have you had any menstrual difficulties (for women only) _____ Describe _____

_____ Do you experience tension, headaches, crying, or other symptoms prior to after your menstrual cycle, please explain _____

Have you ever used drugs other than for medical purposes _____

If yes, please explain _____

Have you ever been arrested _____ If yes, explain _____

Do you drink alcoholic beverages _____ Type, frequency and how much _____

_____

Do you drink coffee _____ How much _____

Other caffeine drinks _____ How much _____

Do you smoke _____ What _____ Frequency _____

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Have you ever had interpersonal problems on the job _____

_____

Have you ever had a severe emotional breakdown, please explain _____

_____

Have you ever seen a counselor or psychiatrist, please explain _____

_____

Are you willing to sign a release of information so that your counselor may obtain social, mental health, or medical records _____

Spiritual:

Denomination _____
Church attending _____
Church attendance per month (circle one) **0 1 2 3 4 5 6 7 8 9+**
Do you believe in God _____ Do you pray _____
Would you say you are a Christian or still in the process of becoming a Christian _____
Have you been baptized _____ How often do you read the Bible
Explain any recent changes in your religious life _____

_____

Religious background of spouse _____
Have you come to a place in your spiritual life where you can say that you know for certain that if you were to die today you would go to heaven **YES** _____ **NO** _____
What was the basis for answering the way you did _____

_____

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Personality Information: Circle the following words which best describe you now.

Active	Ambitious	Self-Confident	Persistent	Nervous	Hardworking	Impatient
Moody	Impulsive	Often-Blue	Excitable	Imaginative	Calm	Serious
Shy	Easy-Going	Good-Natured	Introvert	Extrovert	Likeable	Leader
Quiet	Hard-Boiled	Submissive	Self-Conscious	Lonely	Sensitive	Other

Have you ever felt people were watching you	**YES**	_____	**NO**	_____
Do people's faces ever seem distorted	**YES**	_____	**NO**	_____
Do you ever have difficulties distinguishing faces	**YES**	_____	**NO**	_____
Do colors ever seem too bright	**YES**	_____	**NO**	_____
Are you sometimes unable to judge distance	**YES**	_____	**NO**	_____
Have you ever heard voices	**YES**	_____	**NO**	_____
Do you ever see images or people	**YES**	_____	**NO**	_____
Do you have difficulties hearing	**YES**	_____	**NO**	_____
Do you have problems sleeping	**YES**	_____	**NO**	_____
How many hours of sleep do you get each night	**YES**	_____	**NO**	_____

Personal Problem Checklist:

	Addiction (describe)				
			Dominating		Loneliness
	Anger		Drunkenness		Lust
	Anxiety		Easily upset		Memory
	Apathy		Envy		Moodiness
	Appetite		Fear		Perfectionism
	Bitterness		Finances		Prideful
	Changes in lifestyle		Gluttony		Sex
	Children		Guilt		Rebellion
	Communication		Conflict (fights)		Health
	Sleep		Spousal Abuse		Homosexuality
	Decision-making		Impotence		Deception
	Depression		In-laws		Other

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PRESENTING PROBLEM QUESTIONNAIRE:

BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. What is the problem or concern that brings you here today?

_____

_____

_____

_____

_____

_____

2. What have you done about this problem?

_____

_____

_____

_____

_____

_____

3. What are your expectations from counseling?

_____

_____

_____

_____

_____

_____

4. Is there any other information we should know about?

_____

_____