Grace Biblical Counseling Ministry

Personal Data Inventory

Walnut Creek Baptist Church
Worship. Growth. Friendship.

Name					
Address					
Sex:	Age:	Date of Birth:	Phone Number:		
Highest Education:	High School	GED	College	Graduate	Post Graduate
Other Education or Training					

PERSONAL HISTORY

Parents:	Name	Age	Occupation	Marital Status
Father				
Mother				
Step-parent				

Guardian:	Name	Relation to You	Dates of Guardianship
	Reason for Guardianship:		

Siblings:	Name	Age	Relationship to You	Marital Status

Circle which might have applied during your childhood and/or adolescence:

School problems	Family problems	Medical problems	Drug/Alcohol abuse problems
Legal problems	Social problems	Bullying	Abuse

Please explain:

OCCUPATIONAL HISTORY

What is your current occupation?

What jobs have you held in the past?

Does your present work satisfy you? If not, please explain.

Present Annual Income:

MARITAL HISTORY

Marital Status:	Single	Engaged	Married	Remarried	Separated	Divorced	Widowed

Your Present Marriage	Date of Marriage	Have you ever been separated from your present spouse? When?

Spouse	Name	Age	Occupation	Religious Background

Children	Name	Age	Relation	From Previous Marriage?

Your Previous Marriages	Date: (from/to)	Date:	Date:	Date:	Date:

RELIGIOUS HISTORY

Denominational preference:

Church presently attended (Name and address):

Pastor's name:	Permission to consult with pastor? Yes No	Do you believe in God? Yes No Uncertain

Do you consider yourself "saved?"
Yes No Not sure what this means

How much do you read the Bible? Often Occasionally Never

Do you have regular devotions?

MEDICAL HISTORY

Rate your health:	Very good	Good	Average	Declining	Other:
Your approximate weight		Recent weight changes?		Lost	Gained

List all important present or past illnesses, or injuries, or handicaps:

Date of last medical examination:	Outcome of examination:

Have you had any of the following physical problems? Please check:

Heart problems	Bulimia	Menstrual irregularities	Liver problems
Anorexia	Kidney problems	Visual problems	Hallucinations
Head injury/concussion	Sensory distortion	Change in sexual drive	Stroke
Weakness	Seizures	Fatigue	Problems walking
Brain tumor	Heat/cold sensitivity	Unusual hair loss	Multiple Sclerosis
Rashes	Parkinson's disease	Bowel/bladder	Memory problems
Blackouts	Nausea/vomiting	Episodic disorientation	Amnesia
Weight change	Tremors	Impotence	Personality change
Thyroid dysfunction	STD	Deja vu	Diabetes
Constant hunger	Changes in consciousness	Hypoglycemia	Food cravings
Lung problems	Fever	Headaches	Allergies
Pneumonia	Dizziness	Cancer	Speech Problems
Stiff neck	High Blood Pressure	Incoordination	HIV/AIDS

List previous surgeries (those which required anesthesia):

List all prescription and over-the-counter medications: Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin. (Attach separate page if necessary)

What is your average daily caffeine consumption? Include coffee, tea chocolate, stimulants, and caffeinated soft drinks.

How many hours of sleep do you average each night? Have there been any recent changes? Is this sleep restful?

Have you or others noticed any changes in your personality (anger, mood swings, withdrawal) thinking and memory, or work habits?

As you see yourself, what kind of person are you? (describe yourself)

Have you used drugs for other than medical purposes? Yes No	If yes, what and for how long?	How many alcoholic beverages do you consume per week?

Have you had any psychotherapy or counseling before? If yes, what was the occasion and the outcome?

Are you willing to sign a release of information form so that your counselor may receive information from social, psychiatric, or medical reports?

PERSONAL ASSESSMENT

State in your own words the nature of the main problem(s) that bring you for counseling:

When did your problems begin? Please specify a date if possible.

Please describe any significant events occurring at that time.

What have you done to try to resolve your problems(s)?

What would you like us to do for you? What kind of help do you want from us?

Is there any other information we should know?

This form continues on the next page….

Counseling Agreement and Consent to Counsel

I understand that the counseling offered through Grace Biblical Counseling Ministry of Walnut Creek Baptist Church is provided according to the counselor's interpretation of the Holy Scriptures. No claim is made or implied to licensure by the Commonwealth of Pennsylvania or any by other state.

I understand that confidentiality may be assured only to the reasonable extent of privacy that the case and client will not be discussed by name publicly. In cases where the counselor is informed of illegal activity, or if a counselee is in danger of harming himself or others, no confidentiality will be held. Any case of child endangerment, neglect, or abuse ***that has not been previously reported*** will be reported to the appropriate authorities.

For members of Walnut Creek Baptist Church:

If you are a member of Walnut Creek Baptist Church, the senior pastor will be informed only that you are being counseled. The pastor will be fully informed of any cases which may be cause for church discipline as outlined in the Constitution and By-Laws of Walnut Creek Baptist Church or which may include immediate danger to the members or ministry of Walnut Creek Baptist Church.

Statement on the Use of Medication

Grace Biblical Counseling does not practice medicine. Therefore, the cessation of any medication is a decision to be made between a counselee and his or her physician. Any discussions of the use of medication would be incidental and will only be instructive to the same degree as that which is made openly available in the public domain by the pharmaceutical companies; i.e. common side effects, normal use, and expected results; or to assess the extent to which the counselee has been assisted by medication.

I willfully enter into this counseling agreement.

I promise that I will not harm myself and that if I feel that I am in danger of harming myself or others that I will contact one of the crisis numbers below:

- Erie Crisis Hotline: (814) 453-5656
- Crawford County Crisis Hotline: (814) 724-2731 or (800) 315-5721
- National Suicide Prevention Lifeline: 1 (800) 273-8255

_____
Name (printed)

_____ _____
Signature