



## Personal Data Inventory New Counselee Intake Form

**Please answer to the best of your ability. Any question you feel uncomfortable answering, you can leave blank and discuss with your counselor.**

1. Name \_\_\_\_\_ 2. Phone \_\_\_\_\_ Cell \_\_\_\_\_
3. Email address: \_\_\_\_\_
4. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_
7. Birth Date: \_\_\_\_\_ 8. Sex:  Male  Female 9. Age: \_\_\_\_\_
10. Marital Status:  Single  Engaged  Married  Separated  Divorced  Remarried  Widow
11. Education:  Elementary  High School  GED  College  Graduate  Degree: \_\_\_\_\_
12. Other Training (List type and years): \_\_\_\_\_
13. Hobbies: \_\_\_\_\_
14. Referred to us by: \_\_\_\_\_ Relationship: \_\_\_\_\_
15. If you were raised by anyone other than your own parents, briefly explain: \_\_\_\_\_  
\_\_\_\_\_

16. How many siblings do you have? Older brothers: \_\_\_ Sisters: \_\_\_ Younger brothers: \_\_\_ Sisters: \_\_\_

### **Marriage Information:**

17. Name of Spouse: \_\_\_\_\_ Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_ Age: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Religion: \_\_\_\_\_ Education: \_\_\_\_\_
18. Does your spouse know you are coming for counseling?  Yes  No
19. Is your spouse willing to come to counseling?  Yes  No  Uncertain
20. Have you ever been separated?  Yes  No When? From: \_\_\_\_\_ Till: \_\_\_\_\_
21. Your ages when married: Husband: \_\_\_\_\_ Wife: \_\_\_\_\_ Wedding Date: \_\_\_\_\_
22. How long did you know your spouse before marriage? \_\_\_\_\_
23. Length of steady dating with spouse: \_\_\_\_\_ Length of engagement: \_\_\_\_\_
24. Give brief information about any previous marriages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Children Information:**

25. List the information about your children below :

\*(PM) NAME BIRTHDATE SEX LIVING? EDUCATION MARITAL STATUS  
yes/no

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\*Check this column if child is by previous marriage

**History Information:**

26. Have you dealt with severe emotional struggles in your past?  Yes  No

27. Have you ever had any therapy or counseling before?  Yes  No

If yes, list counselor or therapist and dates:

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What was the result of your counseling?

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28. Check off any of the following words which best describe you now:

- |   |                                   |                                 |                                    |                                    |
|---|-----------------------------------|---------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> self confident | <input type="checkbox"/> anxious  | <input type="checkbox"/> moody  | <input type="checkbox"/> often sad | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> excitable      | <input type="checkbox"/> calm     | <input type="checkbox"/> shy    | <input type="checkbox"/> fearful   | <input type="checkbox"/> introvert |
| <input type="checkbox"/> extrovert      | <input type="checkbox"/> likeable | <input type="checkbox"/> lonely | <input type="checkbox"/> bitter    | <input type="checkbox"/> angry     |

29. List fears you have:

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30. Have you ever been arrested?  Yes  No Reason: \_\_\_\_\_

**Health Information**

32. Rate your health:  Very Good  Good  Average  Declining  Other \_\_\_\_\_

33. Approximately how much sleep do you get each night? \_\_\_\_\_

34. When do you go to sleep at night? \_\_\_\_\_ When do you get up? \_\_\_\_\_

35. Your approximate: Weight \_\_\_\_ Height \_\_\_\_ 36. Weight changes recent Lost \_\_\_\_ Gained \_\_\_\_

37. Do you have any chronic medical conditions? -List and Describe below:

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38. When is the last time that you have been seen by a doctor for a physical? \_\_\_\_\_

39. Are you presently taking prescription medications?  Yes  No

Please list: \_\_\_\_\_

39. How much alcohol do you consume?  Daily  Weekly  Occasionally  Very little or never

40. In the past five years, have you used illegal or excessive prescription drugs?  Yes  No  Not sure

**Religious Background**

41. Church attended in childhood (if any): \_\_\_\_\_ City: \_\_\_\_\_

42. What church do you now attend (if any)? \_\_\_\_\_ City: \_\_\_\_\_

43. What is the number of church activities you attend per month? (circle)

0      1      2      3      4      5      6      7      8      9      10      10+

44. Do you desire for us to contact your pastor for background information?  Yes  No

45. Do you believe in God?  Yes  No  Uncertain

46. Do you pray to God?  Yes  No  Occasionally

47. Are you a Christian?  Yes  No  Uncertain

48. Have you come to the 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  Not Sure

49. How often do you read the Bible?  Often  Occasionally  Never

50. Does your family regularly read the Bible and pray together?  Often  Occasionally  Never

51. Religious background of spouse: \_\_\_\_\_

52. If you died today and God asked you "Why should I let you into my heaven?" What would you say?

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53. Explain any recent changes in your religious/spiritual life, if any:

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**Briefly answer the following questions that help us understand your situation better**

1. How do you describe the issues with which you are struggling?

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2. What have you tried to do about it?

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3. How do you hope counseling might help? (What are your expectations in coming here?)

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4. What brings you here at this time? (Did any recent event cause you to schedule the appointment now?)

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5. Is there any other information you think we should know to help you?

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