**BIBLICAL COUNSELING FOUNDATION**
**CCEF-Montana***
Billings, Montana
406-294-5533
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# Personal Data Inventory Form

Date: _______________________________ Date of Birth: ________________________

Name: ____________________________________________ Sex:___________________ Age: __________

Address: __________________________________________ City/State: __________________ Zip: _________

Home Phone: ____________________ Cell Phone: ____________________ Other: _______________________

Occupation: _________________________________________________________________________________

Education/Training: ___________________________________________________________________________

Email Address: _______________________________________________________________________________

Referred By: _________________________________________________________________________________

| PERSONAL HISTORY | | | | |
|---|---|---|---|---|
| FATHER'S NAME | AGE | | OCCUPATION | MARITAL STATUS |
| MOTHER'S NAME | AGE | | OCCUPATION | MARITAL STATUS |
| GUARDIAN'S NAME (If Applicable) | RELATIONSHIP TO YOU | DATE OF GUARDIANSHIP<br>FROM TO | | |
| REASON FOR GUARDIANSHIP | | MORE THAN ONE GUARDIANSHIP<br>YES ___ NO ___ | | |

| SIBLINGS | | | |
|---|---|---|---|
| NAME | AGE | RELATIONSHIP (BROTHER, STEPSISTER, ETC.) | MARITAL STATUS |
| NAME | AGE | RELATIONSHIP (BROTHER, STEPSISTER, ETC.) | MARITAL STATUS |
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| NAME | AGE | RELATIONSHIP (BROTHER, STEPSISTER, ETC.) | MARITAL STATUS |
| NAME | AGE | RELATIONSHIP (BROTHER, STEPSISTER, ETC.) | MARITAL STATUS |
| MORE THAN SIX SIBLINGS? | YES _________________ NO _________________ | | |

| INDICATE WHICH MIGHT HAVE APPLIED DURING CHILDHOOD AND/OR ADOLESCENCE. | Emotional/Behavioral Problems ___ School Problems ___ Family Problems ____<br>Medical Problems ___ Drug/Alcohol ___ Social Problems ___ Legal Problems ___ |
|---|---|

Has anyone in your immediate family been hospitalized or received some form of professional help for psychological problems? If so, please specify who, when they received help, and the nature of the problem.

_______________________________________________________________________________

_______________________________________________________________________________

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| OCCUPATIONAL HISTORY |
|---|
| WHAT POSITIONS HAVE YOU HELD IN THE PAST? |
| DOES YOUR PRESENT WORK SATISFY YOU? IF NOT, PLEASE EXPLAIN. |

## MARITAL HISTORY

MARITAL STATUS: Engaged ___ Married ___ Remarried ___ Separated ___ Divorced ___ Widowed ___

SPOUSE'S NAME: ________________________________________ AGE: _____ OCCUPATION: ______________________

SPOUSE'S RELIGIOUS BACKGROUND: _____________________________ DATE OF MARRIAGE: _____________________

SPOUSE'S EDUCATION: _________________________________________________________________________________

HAVE YOU EVER BEEN SEPARATED FROM YOUR PRESENT SPOUSE? (If yes, please specify when) Yes _____ No ______

1. From: ___________ To: ____________ 2. From: ___________ To: _____________

PREVIOUS MARRIAGES (If applicable)

From ___________ To _____________ Children from Marriage ___________________________________________________

From ___________ To _____________ Children from Marriage ___________________________________________________

YOUR SPOUSE'S PREVIOUS MARRIAGES (If applicable)

From ___________ To _____________ Children from Marriage ___________________________________________________

From ___________ To _____________ Children from Marriage ___________________________________________________

## CHILDREN

Name ________________________ Age ____ Relationship (Daughter, Son, Stepson, etc.) __________________________

Living at Home: Yes ___ No ___ Marital Status ______________ Occupation ______________________________

Name ________________________ Age ____ Relationship (Daughter, Son, Stepson, etc.) __________________________

Living at Home: Yes ___ No ___ Marital Status ______________ Occupation ______________________________

Name ________________________ Age ____ Relationship (Daughter, Son, Stepson, etc.) __________________________

Living at Home: Yes ___ No ___ Marital Status ______________ Occupation ______________________________

Name ________________________ Age ____ Relationship (Daughter, Son, Stepson, etc.) __________________________

Living at Home: Yes ___ No ___ Marital Status ______________ Occupation ______________________________

Name ________________________ Age ____ Relationship (Daughter, Son, Stepson, etc.) __________________________

Living at Home: Yes ___ No ___ Marital Status ______________ Occupation ______________________________

## RELIGIOUS BACKGROUND

Denominational Preference ______________ Name of Church Attending __________________________________________

Current Church Address __________________________________________________ Church Phone Number _____________

Pastor's Name ____________________________ Do we have permission to consult with your Pastor? Yes _____ No _____

Do you believe in God? Yes ___ No ___ Uncertain ___ Do you consider yourself saved? Yes ___ No ___ Not Sure ______

If you were to die and stand before God and He asked you why He should permit you to enter heaven, how would you respond? ___________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

## MEDICAL HISTORY

- ☐ Heart Problems
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Head Injury, concussion
- ☐ Stroke
- ☐ Seizures
- ☐ Brain Tumor
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Blackouts
- ☐ Amnesia
- ☐ Tremors
- ☐ Thyroid dysfunction
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Lung problems
- ☐ Allergies
- ☐ Cancer
- ☐ Bulimia
- ☐ Anorexia
- ☐ Visual distortions
- ☐ Weakness
- ☐ Fatigue
- ☐ Heat/cold sensitivity
- ☐ Bowel/bladder problems
- ☐ Nausea or vomiting
- ☐ Recent weight change
- ☐ Impotence
- ☐ Physical change
- ☐ Constant hunger
- ☐ Food cravings
- ☐ Fever
- ☐ Pneumonia
- ☐ Speech problems
- ☐ Uncoordination
- ☐ Menstrual irregularities
- ☐ Hallucinations
- ☐ Change in sexual drive
- ☐ Problems walking
- ☐ Unusual hair loss
- ☐ Rashes
- ☐ Memory problems
- ☐ Episodic disorientation
- ☐ Personality change
- ☐ Déjà vu
- ☐ Changes in Consciousness
- ☐ Headaches

LIST PREVIOUS SURGERIES (Those which required anesthesia).

LIST ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATION YOU ARE PRESENTLY TAKING. (Include diet pills, laxatives, birth control pills, cold & allergy medicines, aspirin.)

| 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?<br>Yes ______ No ______ | Is this sleep restful?<br>Yes _____ No _____ |
|---|---|---|---|

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

State in your own words the nature of the main problem(s).

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

Please describe any significant events occurring at that time.