PERSONAL DATA INVENTORY

Date / /

Please completely fill out this form and make it available to your counselor before your first counseling session.

PERSONAL DATA

Name	Sex: ☐ Male ☐ Female	Age
Email	Date of Birth / /	
Home Phone ( )	Cell Phone ( )	
Address		

OCCUPATION DATA

Education (last year completed)	
Current Occupation or Responsibility *(e.g. Doctor, stay at home mom, etc.)*	
Annual Household Income	Business Phone ( )
Business Address	

Does your current occupation or responsibility satisfy you? ☐ Yes ☐ No

If no, please explain: ____

____

FAMILY DATA

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

Spouse's Name	Spouse's Religion:
Current Occupation or Responsibility:	

Children:

Name	Age	Sex	Previous Marriage
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

PAST COUNSELING DATA

Have you ever seen a psychologist, psychiatrist or received counseling before? ☐ Yes ☐ No

If yes, list counselor(s) ______________________________ and dates ____ /____ /____ to ____ /____ /____

______________________________ and dates ____ /____ /____ to ____ /____ /____

______________________________ and dates ____ /____ /____ to ____ /____ /____

______________________________ and dates ____ /____ /____ to ____ /____ /____

What did the process look like? *(what information was helpful, which books did you read, what topics were addressed)*

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What was the outcome?

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

☐ School problems ☐ Family problems ☐ Medical problems ☐ Social problems ☐ Legal problems
☐ Emotional Abuse ☐ Sexual Abuse ☐ Physical Abuse ☐ Financial Difficulty ☐ Drug/Alcohol abuse

Please explain: ____

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SPIRITUAL LIFE DATA

Sunday Morning attendance per month: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Are you a member or regular attender of **church**? Yes No ☐ ☐

If not, where do you attend church? ____

Are you part of a Small Group: ☐ Yes ☐ No Who is your small group leader: ____________________

Do you consider yourself “saved”? ☐ Yes ☐ No ☐ Not sure what you mean

Explain recent changes in your religious life, if any: ______________________________________

____

If you were to die and stand before God and He asked you why He should permit you to enter Heaven, how might you respond?

____

____

THEOLOGICAL ASSESSMENT

01. All truth can be found if I just look within myself .... ☐ Yes ☐ No
02. God can bring peace in the midst of life's struggles .... ☐ Yes ☐ No
03. I am a Christian as long as I go to church, pray, and read my Bible .... ☐ Yes ☐ No
04. People naturally tend to do bad things .... ☐ Yes ☐ No
05. I should do whatever feels right .... ☐ Yes ☐ No
06. God is in control, even when bad things happen .... ☐ Yes ☐ No
07. God only loves me when I do good .... ☐ Yes ☐ No
08. Even if it doesn't feel good, I might have to do it .... ☐ Yes ☐ No
09. If God were totally good, He would never let anything bad happen .... ☐ Yes ☐ No
10. Our emotions and senses can often fool us .... ☐ Yes ☐ No
11. Suffering has no meaning and should be avoided whenever possible .... ☐ Yes ☐ No

SPIRITUAL DISCIPLINES ASSESSMENT

01. How often do you pray to God? .... ☐ Never ☐ Occasionally ☐ Often
02. How much do you read the Bible? .... ☐ Never ☐ Occasionally ☐ Often
03. Do you have regular family devotions? .... ☐ Yes ☐ No
04. How often do you attend church? .... ☐ Never ☐ Occasionally ☐ Often
05. Do you regularly support the church through offering? .... ☐ Yes ☐ No
06. List the ways you serve at your chuch____
07. How often do you share the gospel? .... ☐ Never ☐ Occasionally ☐ Often

GOSPEL ASSESSMENT

In a paragraph or two, explain how your faith in the gospel has changed the way you live?

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MEDICAL ASSESSMENT

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

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

1. List previous surgeries (those which required anesthesia): ____________________

2. List all prescription and over-the-counter medications (Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin): ____________________

   ____

   ____

3. Explain any past or current abuse of alcohol, smoking or illicit drugs: ____________________

4. What is your average daily caffeine consumption (Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks): ____________________

5. How many hours of sleep do you average each night? ____________________

   Have there been any recent changes? ____________________

   Is this sleep restful? ____________________

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

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PRE-COUNSELING JOURNAL

Please take some time to think through what has been happening in your life and journal about it. This next section will better help us get to know you and match you with a counselor. Use the following questions as guides to journal about what has been going on in your life and in your heart.

1. Describe the problem in your life as you see it. Include when it began and any other significant events that occurred around the same time.

2. What have you done to try and resolve the problem on your own?

3. What do you desire to happen in this situation? What don't you feel like you're getting?

4. What types of thoughts come to your mind in your current situation when you feel disappointed?

5. What would make this situation better? What do you fear happening?

6. What are you hoping we can do for you? What kind of help would you like?

7. Is there any other information we should know?

Professional Services Agreement

We are pleased that you have chosen Dr. Long. This form gives you some information about our professional relationship. Your appointment is with the therapist whose name appears at the top of Page 1. You are encouraged to ask him/her any questions regarding their background, credentials, professional experience or philosophy.

CONFIDENTIALITY INFORMATION

The office of Dr. Long is concerned about confidentiality. As Christian counselors, we believe God expects us to be trustworthy and we believe it is God's will for His people to know safety and security. It is the goal of the office of Dr. Long to provide an environment in which our clients may place their trust and confidence. Under both federal and state law, confidentiality means communication with your therapist and any records pertaining to your identity, evaluation, or treatment will be held in confidence. Where federal and state laws differ, we comply with the stricter standard to insure that your right to confidentiality is respected at all times. Also, beyond the law, we know that a sense of safety and security are necessary to the process of healing in which our clients are engaged. Holding to God's law as stated in His Word and by complying with federal and state laws, the office of Dr. Long will maintain confidentiality to the fullest extent personally and professionally. You have a right to confidentiality.

Our Confidentiality Policy and Privacy Practices Brochure is the bi-folded blue document you have received with this agreement. It is your copy to keep. It states more fully our policies and practices and your rights therein.

Please read the document before signing this agreement.

If you believe the Confidentiality Policy and Privacy Practices document does not answer all your questions regarding confidentiality, talk with your therapist about any concerns you may still have.
Your signature at the end of this document indicates consent to use your personal health information for routine practices according to the law for treatment, payment, and health care operations. You may revoke this consent in writing at any time, except to the extent that the office of Dr. Long has taken action relying on this consent.

Rights
You have a right to be provided with professional and respectful care. You have a right to know your therapist's assessment of the problem, the recommended treatment, and resources available to help deal with your situation.
You also have the right to refuse our suggestions.

Responsibilities
1. To be honest, open, and willing to share your concerns
2. To ask questions when you don't understand or need clarification
3. To discuss any reservations you have about your treatment plan
4. To follow the agreed upon treatment plan
5. To report changes or unexpected events related to your problem
6. To keep appointments whenever possible or to call and cancel within 24 hours prior to your appointment. (see payment information – you will be charged the entire session fee for appointments not cancelled with 24-hour notification)

Remember, you are responsible for your thoughts, feelings, actions, and growth. We are here to help facilitate that growth to the best of our ability.

Signed   Date   /   /

Print Name

Signature of Parent / Legal Guardian (if under 18)

SCHEDULING

Please check the time and days that you are available for counseling

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Early morning (6am-9am)							
Morning (9am-12pm)							
Early afternoon (12pm-3pm)							
Afternoon (3pm-6pm)							
Evening (6pm-9pm)							