EQUIPPING FOR LIFE AND MINISTRY COUNSELING CENTER
E.L.M.C.C.
A MINISTRY OF GRACE FELLOWSHIP CHURCH
PERSONAL DATA INVENTORY
(Please completely fill out this form and make it available to your counselor before your first counseling session.)

Name_____

Address_____
(Street) (City) (State) (Zip)

Sex_____Age_____Date of Birth_____Phone_____

Occupation_____Education/Training_____

Business Address_____Phone_____

Referred for counseling by_____

PERSONAL HISTORY

Parents: Name Age(if living) Occupation Marital Status

Father:_____

Mother:_____

Guardian Name (if applicable)_____Relation to you_____

Reason for Guardianship_____Date_____to_____

Siblings: Name Age Relationship Marital Status

_____
_____
_____
_____
More than five? Yes No

Indicate which might have applied during your childhood and/or adolescence:
School problems_____Family problems_____Medical problems_____
Drug/Alcohol abuse problems_____Social problems_____Legal problems_____
Please explain:_____
_____
_____
_____

OCCUPATIONAL HISTORY

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 (if applicable)

Spouse's name_____Age____Occupation_____

Spouse's religious background_____Education_____

Date of marriage_____Have you ever been seperated from your present spouse?

If yes, please specify when: 1)_____to_____ 2)_____to_____

Children

Name Relationship Living at Home Age Marital Status Occupation (son, step-daughter, etc.)

_____
_____
_____
_____
_____
_____
_____
_____

Your Previous Marriages (if applicable)

Date	Children from this marriage
_____to_____	_____
_____to_____	_____

Spouse's Previous Marriages (if applicable)

Date	Children from this marriage
_____to_____	_____
_____to_____	_____

RELIGIOUS BACKGROUND

Denominational preference_____
Church presently attended (name and address):

_____Phone_____

Pastor_____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 you mean___

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?

_____

_____

_____

MEDICAL HISTORY

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__
Physical change__	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__

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.

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)

_____

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?

