

Confidential Personal Inventory (In-Take)

Confidentiality: All information obtained on this form or within the counseling session is strictly confidential and is never shared with third parties without the client's permission unless required by law

Name _____ E Mail _____

Address _____ City _____ State ___ Zip _____

Home Telephone _____ Cell _____ Male _____ Female _____ Age _____

Are you attending a local church at this time _____ Church name _____

Referred by _____ Your Vocation _____

Place of business _____

School: Highest grade completed _____ Degrees earned _____

Marital Status: _____ How long? _____ Previously married? _____ How long? _____

If you are divorced, what caused the separation? _____

Dependent children Number _____ Ages _____

Are they all living with you? _____ If not, why? _____

Are your parents living? _____ married or divorced? _____ Is your best friend presently married or divorced? _____

How many siblings? Brothers _____ Sisters _____ married? _____ How many have been divorced? _____

Do you have an addictive problem? If so, what _____ Is there a history of mental illness in your family? _____

Using a scale of 0 to 10 (0 being none) how would you describe your concern for:

Diet _____ Exercise _____ Rest _____ Religion _____

Do any of these concern you and why (briefly) _____

Are you currently under a physician's care and for what? _____

Medications _____ Primary Care Doctor _____

Do you have cravings that are difficult for you to control? What

Do you have trouble sleeping? _____

How would describe yourself sexually? Not active If active, satisfied? or not satisfied?

On a scale of 0 to 10, 0 being none and 10 the greatest... How is your love life in general? _____

Have you ever been physically beaten or sexually molested? If so, briefly describe the circumstances

How would you describe your childhood and upbringing? _____

Are your bills current? _____ Is keeping up financially difficult? _____

How many hours a week do you spend watching TV each week? ____ What is your favorite program? _____

How many hours a week do you spend reading? ____ What do you like to read? _____

What is your religious background? _____ Do you pray? _____ Is it difficult for you? _____

Do you listen to music a lot? _____ What do you enjoy? _____ What is your favorite pastime? _____

Which of the following emotions are you dealing with at this time?

Frustration Anger Anxiety Loneliness Depression Feelings of worthlessness
Hatred Fear of death Suicide Feeling unloved Bitterness Fear of hurting someone

Do you feel like you can express your emotions? I can

easily express them express some but not all suppress my emotions
It is not safe to express them Others disregard how I feel My feelings are too painful to deal with

If you could change one thing in your life, what would it be? _____

Reason for seeking counsel

Printed Name

Signature

Date