PERSONAL DATA INFORMATION FORM — Graham Biblical Counseling

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

Name____ Date:_________________________

Address____

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

Sex_____ Age_____ Date of Birth_______________ Phone (____)________________ Cell Phone (_____)______________

Email_____________________________________ Referred for counseling by_________________________________

In case of an emergency, please contact: ______________________________ Phone Number:(______)________________

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

Education/Training (last year completed)_________________________ Current

Occupation_________________________________

What jobs have you held in the past?

____

____

Does your present work satisfy you? If not, please explain.

____

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 separated 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_______________ Are you a member? Yes___ No___
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___
Church attendance per month: 1 2 3 4 5 6 7 8 9 10+
Have you been baptized? Yes___ No___ How much do you read the Bible? Never___ Occasionally___ Often___
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__ Other__________________

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

2) How many hours of sleep do you average each night? Have there been any recent changes? Is this sleep restful?

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

4) Rate your health: Very Good___ Good___ Average___ Declining___ Other____________________________________

5) Have you ever had any psychotherapy or counseling before? Yes___   No___
(If yes, list counselor or therapist and dates.)

<u>BRIEFLY ANSWER THE FOLLOWING QUESTIONS</u>:

1) What is your problem (what brings you here)? When did your problem begin?

2) What have you done about this problem?

3) What are your expectations from counseling?

4) Is there any other information we should know?

(Please note that all information given will be used in accordance with the Counseling Agreement.)

Please mail or email to:
Graham Church
Attention: Counseling Ministry
7320 Beard Rd.
Perry, MI 48848

(517) 675-5401
counseling@grahamcc.org
www.grahamchurch.org