Safe Haven Counseling Associates

4879 Luster Leaf Circle, #301
Myrtle Beach, SC 29577
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Loving God and Loving People

PERSONAL DATA INVENTORY

Name___________________________ Gender__ Age__ Birth Date___________

Address ____

Phone: (843) 602-3171 or (843) 602-4380
Email: hello@safehavencounseling.me
Website: safehavencounseling.me

(Street/Box) (City) (State) (Zip)
Daytime telephone ___________ Evening telephone ________ Email ______________ Referred by ___________

Section I -- Marital Status/History

Status (circle): Single Engaged Married Separated Divorced Widowed

Your Present Marriage (if applicable):
Spouse's name ____________________ Age __ Spouse's occupation _______________
Date of marriage _____ Place __________ Years married __
If you and your spouse have ever separated, give dates and circumstances:
____

Rate your marriage (circle: 0 as terrible, 5 as excellent): 0 1 2 3 4 5
What might make your marriage better? ____

____

<u>Children from Present Marriage</u> (if applicable):
Name Son/Daughter Age Where Live Marital Status Occupation

____
____
____
____
____

<u>Your Previous Marriages</u> (if applicable):
Name of Spouse Dates Children (Names and Ages)
1. ________________ _____to_____ ____

2. ________________ _____to_____ ____

Has your spouse been previously married?____ How many times?___

Section II -- Occupational Status/History

Education (last level completed) ________ School/Institute __________________________

Occupation _____________________ Name of Company ___________________ City/State ______

Years there ______ Present income (est.) $_________ Work Telephone (____)________________

Does your present work satisfy you? Explain: ____
____

What other job positions have you held in the past? ____________________________________
____

Section III -- Family of Origin History

<u>Parents:</u> Name Age Where Live Marital Status Occupation
Father: ____

Mother: ____

Guardian: _______________ Relation to you: __________ Dates: _________

<u>Brothers/Sisters:</u> (List in order from oldest to youngest; include yourself in that order):
Name Bro/Sis/Step Age Where Live Marital Status Occupation

____
____

____
____
____

Family "Climate": Describe your home life during your childhood and teen years: _______________
____
____

Indicate any problems you experienced as a child or teen:
Family problems___ School problems___ Emotional/behavior problems___ Legal problems___ Medical problems___ Social problems___ Drug/alcohol problems___ Other:____________________

Psychological Problems: Have you, or any parent or brother or sister, been hospitalized or received professional help for "psychological" problems? Specify person, dates, and problem: ________________________
____
____

Section IV -- Religious Status/History

Past Denominational Background _______________ Present Denom. Preference________________

Church Presently Attending ________________________________ City & State ______________
Member: Yes No Average # of times per month you attend ___

Pastor __________________ Telephone ______________ Permission to contact him: Yes No
Do you believe in God? Yes No Unsure

Do you consider yourself "saved?" Yes No Unsure Don't understand the term

How frequently do you pray? Often Occasionally Rarely Never

How frequently do you read the Bible? Often Occasionally Rarely Never

What is your view of the Bible? ____

Have you come to the place in your spiritual life where you know for certain that if you were to die today you would go to heaven? Yes No Unsure
Suppose you were to die and stand before God and he were to say to you, "Why should I let you into my heaven?," what do you think you might say to God? ___________________________________
____

Why do you desire *Christ-centered, biblical* counseling?__________________________________
____

Explain any recent changes in your religious life: ____
____

Section V -- Medical Status/History

Rate your health: Very Good __ Good __ Average __ Poor __ Recent Problems? ________________
Date of last medical exam: __________ Report ____
Your Physician ____ City & State_______________

List any prescription medications you take:

Medication	Treatment for	When began	Daily dosage	Prescribing Physician

List over-the-counter medications you currently take (diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin, etc.): ____
____

List any surgeries which required anesthesia: ____
____

Average daily caffeine consumption? (coffee, tea, chocolate, stimulants, caffeinated soft drinks, etc.)
____

How often do you drink alcoholic beverages? Often Occasionally Rarely Never

How often do you struggle with the temptation to use illegal drugs? Often Occasionally Rarely Never
Average # of hours of sleep each night? ___ Is it restful? ____________________________________

Describe any recent changes in your sleep patterns: ____
____

Have you had any of the following physical problems? Please check.

Heart problems ___	Hypoglycemia ____	Menstrual irregularities ___
Liver problems ___	Lung Problems ____	Hallucinations ____
Kidney Problems ___	Allergies ______	Change in sexual drive ____
Head injury/concussion ___	Cancer ___	Problems walking ___
Stroke ____	Incoordination ___	Unusual hair loss ___
Seizures ____	Anorexia or Bulimia ___	Rashes ___
Brain Tumor ____	Visual Problems ____	Memory Problems ____
Multiple Sclerosis ___	Sensory distortions ____	Episodic disorientation ___
Parkinson's Disease ___	Weakness ____	Personality change ____
Blackouts ____	Fatigue ____	Deja Vu ___
Amnesia ____	Heat/cold sensitivity ___	Changes in consciousness ___
Tremors ____	Bowel/bladder problems ___	Headaches ____
Thyroid dysfunction ___	Nausea or vomiting ___	Dizziness ____
Diabetes ___	Recent weight change ____	Stiff neck ___
High Blood Pressure ___	Impotence ___	Physical changes ___
Constant Hunger ___	Food cravings ___	Fever ___
Gastrointestinal problems ___	Temporo Mandibular Joint ___	Heightened startle reflex __

Pneumonia ___ Speech Problems ___ OTHER? ________________________________

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

Section VI – Legal Actions (if applicable, for example, in conflict or separation/divorce cases)

If you have talked with an attorney about your problem, or intend to, please provide the following info:

Attorney ____________________________ Firm ______________________________________
Address ____ Phone __________________
Date and purpose ____

Has a legal action been filed or is one likely to be filed in this situation? No Yes (If yes, give dates and describe action below.)
____
____

Have you received advice from anyone else regarding this situation? No Yes (If yes, give names and dates below.)
____
____

Section VII -- Problem(s) for which You Want to Know God's Answers

What is the main problem as you see it (What brought you to seek counsel?)
____
____
____
____
____
____
____

What have you done about it?
____
____
____
____
____

What do you want me (us) to do about it?
____
____
____
____

What further information about you should I know?

Date of signing: ________________________________