



518 South 7th Street  
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Communitychristiancounselinginc.com

**PERSONAL DATA INVENTORY**

Date \_\_\_\_\_  
Client's Name: \_\_\_\_\_  
Address: Street \_\_\_\_\_ City, State & Zip: \_\_\_\_\_  
Best Phone: \_\_\_\_\_ OK to leave message? (Y) (N) (circle one)  
Date of Birth: \_\_\_\_\_

**CURRENT ISSUES**

Main reason(s) for contacting our office: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_  
\_\_\_\_\_

Have you Sought counseling for this before? If yes, where, when and with whom?  
\_\_\_\_\_  
\_\_\_\_\_

Do you have family members that have sought counseling or been treated for emotional issues? If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any major loss, trauma, or been the victim of any emotional or physical abuse? If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your current physical health or issues with your health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your physical/medical history. If you are currently under the care of a physician, what is the treatment addressing? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking:

Medication Name

Amount per Day

_____	_____
_____	_____
_____	_____

Describe any recent and major changes in your weight or eating habits? \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

List all those living at your address:

Name

Age

Relationship to You

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MARITAL STATUS - CIRCLE ONE:**

Single    Separated    Married    Divorced    Widowed    Cohabiting

If married, what is your spouse's first name \_\_\_\_\_

If they are employed, what is their occupation \_\_\_\_\_

Briefly describe your marital history \_\_\_\_\_

\_\_\_\_\_

Are your biological parents living? (Y) (N) (circle one) If yes, describe your relationship with them:

\_\_\_\_\_

\_\_\_\_\_

**YOUR FAITH JOURNEY**

Are you a Christian? (Y) (N) (circle one) If yes, for how long? \_\_\_\_\_

If no, what do you believe about life/death? \_\_\_\_\_

\_\_\_\_\_

Why did you seek Christian Counseling? \_\_\_\_\_

\_\_\_\_\_

Briefly describe your prayer life \_\_\_\_\_

\_\_\_\_\_

Do you attend church regularly? (Y) (N) (circle one)

If yes, which church? \_\_\_\_\_

Do you read the Bible regularly? (Y) (N) (circle one)

How would you describe your relationship with the Lord? \_\_\_\_\_

\_\_\_\_\_

### **SUBSTANCE USE/ABUSE**

How would you describe your use of alcohol? (circle one)

- 1) Never have use it 2) Used to use it but no more 3) Drink Occasionally  
4) Drink Often 5) I may have a drinking problem 6) I am an alcoholic

Have you ever used illegal drugs? (Y) (N) (circle one) If yes, which drug(s) and how long ago?

\_\_\_\_\_

Do you have a family history of drug/alcohol use/abuse? (Y) (N) (circle one) If yes, describe:

\_\_\_\_\_

### **YOUR EDUCATION**

Highest level of education completed (circle one)

GED - High School - vocational training - College - Advanced degree(s)

Year of last graduation \_\_\_\_\_

### **MILITARY SERVICE**

Branch of service: \_\_\_\_\_ Type of Discharge \_\_\_\_\_

Are you a combat veteran? (Y) (N) (circle one)

If yes, which theater? \_\_\_\_\_

Did you sustain any injuries associated with your service? If yes, what type?

\_\_\_\_\_

Did you receive any disability associated with the injury? (Y) (N) (circle one)

### **EMPLOYMENT HISTORY**

Are you currently employed? (Y) (N) (circle one)

If yes, where: \_\_\_\_\_ for how long? \_\_\_\_\_

What other jobs have you held in the past 3 years? \_\_\_\_\_

**LEGAL HISTORY**

Are you currently involved in any legal actions that could influence your counseling? Please describe:

\_\_\_\_\_  
\_\_\_\_\_

Do you anticipate asking your counselor to testify? (Y) (N) (circle one)

**DISABILITIES**

Have you ever been diagnosed by a medical professional as having a disability? (Y) (No) (circle one)

If yes, please describe \_\_\_\_\_

What special assistance/accommodations do you require, if any? \_\_\_\_\_

**EMERGENCY CONTACT**

Who do you designate as an emergency contact?

Name Phone Number

\_\_\_\_\_  
\_\_\_\_\_

**OUR FEE SCHEDULE**

Our sliding scale fee schedule is based on annual family income. Please check the level that applies.

\_\_\_ Up to \$50,00 per year ..... \$55.00 per counseling session

\_\_\_ Up to \$60,000 ..... \$65.00 per session

\_\_\_ Up to \$70,000 ..... \$75.00 per session

\_\_\_ Up to \$80,000 ..... \$85.00 per session

\_\_\_ Up to \$90,000 ..... \$95.00 per session

**We do not bill any insurance for our services, but we can provide an insurance coded receipt.  
Some insurance companies may reimburse for services. Most will not.**