Trinity Counseling and Training Center
A Ministry of Trinity Bible Church,
532 East Madison, Suite 109, Powell, WY 82435

Personal Data Inventory (PDI)

Personal

Name _____ Phone _____
Address _____Email_____
Employed Yes□ No □ Employer_____
Gender _____ Birth date _____ Age _____Referred by _____

Marriage and Family

Current Marital Status: Single □ Married □ Remarried □ Separated □ Divorced □ Widowed □
Have you been married previously? Yes □ No □ How many times: _____
Name of Current Spouse _____ Date of Marriage _____
Spouse's Age _____ Spouse's Religious Affiliation _____
Is spouse aware you have come for counseling? Yes □ No □
In your current marriage have you ever been separated? Yes □ No □ When? From _____ To _____
Have either of you ever filed for divorce? Yes □ No □ When? _____

Information about Children

Child's Name	Age	Gender	Living with you? (Yes/No)	Married (Yes/No)	By Previous Marriage	Adopted	Foster

Your Childhood: Is there anything significant we should know about your childhood?

_____
_____
_____

Health Information

Rate your health: Very good □ Good □ Average □ Declining □ Other □

Date of last medical exam: _____ Results: _____

Are you presently taking medication? Yes □ No □ If yes, please list them*

Medication	Dosage	Frequency	Prescribed For?	Date Began Taking

*Attach additional page if necessary

Have you had any counseling or psychotherapy before? Yes □ No □ if yes, please explain:

Where? _____ When? _____

Purpose? _____

Have you ever had a severe emotional upset? Yes □ No □ Explain: _____

_____

Have you suffered significant loss from serious social, business, financial or personal circumstances?

Yes □ No □ Explain: _____

_____

Have you ever been arrested? Yes □ No □ Explain: _____

Please check any struggles or difficulties that you have had in the last 6 months.

	Change in appetite (increase or decrease)		Problems concentrating
	Difficulty sleeping/insomnia		Low motivation
	Change in weight (increase or decrease)		Isolating from others
	Fatigue/low energy		Frequent anger
	Feelings of inferiority		Depressed mood/sadness
	Tearful/crying spells		Anxiety/fear
	Hopelessness		Panic attacks
	Bitterness		Impotence
	Lifestyle change		Financial strain
	Pornography		Substance abuse
	Conflict in relationships		Guilt
	Homosexuality		Chronic pain
	Addiction		Self injury
	Suicidal thinking		Deceit / Deception
	Abuse (Type: _____)		Grief
	Change in sexual drive (increase or decrease)		Headaches
	Children		Drunkenness
	Communication		Perfectionism
	In-laws		Moodiness

Have you ever-used drugs for anything other than medical purposes: _____
If yes, please explain: _____
Have you ever used illegal drugs: Yes □ No □
Have you ever considered yourself addicted to a substance: Yes □ No □ Explain: _____
Do you drink alcoholic beverages: _____ If so, how frequently and how much:_____
Do you smoke: _____What: _____Frequency:_____
Have you ever had interpersonal problems on the job: Yes □ No □ Explain:_____
_____

Religious Background

Do you regularly attend a church? Yes □ No □ Church name: _____
Denomination: _____ Are you a member? _____ Pastor: _____
Does your Pastor know you are seeking counseling? Yes □ No □
Do we have permission to contact your Pastor? Yes □ No □ Phone Number:_____
Do you believe in God? Yes □ No □ Uncertain □
Have you come to the place in your spiritual life where you know with certainty that if you were to die tonight you would go to heaven? Yes □ No □ Uncertain □ If yes, when? _____
If yes, what is your basis for answering the above question as you did?_____
_____
_____
_____
Church attendance per month: _____ Do you read your Bible? Yes □ No □ Frequency _____
Do you pray? Yes □ No □ Frequency _____
Ministry involvement in the church: _____
Please note any recent changes in your spiritual life: _____
_____
_____

Women Only

Have you had any menstrual difficulties:_____ If you experience tension, tendency to cry, other symptoms prior to your cycle, please explain:_____
Is your husband willing to come to counseling?_____
Is he in favor of your coming?_____ If no, please explain:_____

Complete the following questions. (Attach additional page if necessary)

1. Please describe the current problems (what brings you here) and when they began.

2. Please describe any significant events occurring at the time your problems began.

3. What have you done to try to resolve your problem(s)? Be specific.

4. What led you to seek help now?

5. What would you like us to do for you? What kind of help do you want from us?

6. Is there any other information we should know?

By signing this document I am indicating that:
1. I have read the Trinity Counseling and Training Policies, Procedures and Consent Form
2. I am enrolling myself into counseling of my own will.

_____ _____
Signature Date

_____ _____
Signature of Guardian (if applicable) Date