HOPE BIBLE CHURCH

BIBLICAL COUNSELING

Personal Information Form (PIF)

Name: _____ Gender: _____

Age: _____ Today's Date: _____

Address: _____

_____

Email: _____

Best phone number to reach you: _____

Referred to us by: _____

Section I -- Marital Status/History

Status: (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, please give dates and circumstances:

_____

Rate your marriage 1-10 (0 terrible, 10 excellent): What might make it better?

_____

Children from Present Marriage (if applicable):

Name: _____ Son/Daughter Age: _____

Where does he/she live? _____ Marital Status:_____

Occupation: _____

Name: _____ Son/Daughter Age: _____

Where does he/she live? _____ Marital Status:_____

Occupation: _____

Name: _____ Son/Daughter Age: _____

Where does he/she live? _____ Marital Status:_____

Occupation: _____

Your Previous Marriages (or Relationships that produced children) (if applicable):

	Name of Spouse/Partner	Dates	Children (Names and Ages)
1.	_____	_____to_____	_____
2.	_____	_____to_____	_____

Has your spouse been previously married? _____

How many times? _____

Children (Names and Ages):

_____

_____

Section II -- Occupational Status/History

Education (last level completed): _____

School/Institute: _____

Occupation: _____

Employer: _____

How long? _____ City: _____

Present income range:
($0-$30,000) ($30,000-$60,000) ($60,000-$90,000) or ($90,000+)

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

Father Name: _____ Age: _____ Marital Status: _____

Where does he live? _____ Occupation: _____

Mother Name: _____ Age: _____ Marital Status: _____

Where does she live? _____ Occupation: _____

Guardian Name: _____ Relation to you: _____

Dates: _____

Brothers/Sisters (List in order from oldest to youngest; include yourself in that order):

Name _____ Bro/Sis/Step Age: _____

Where does he/she live? _____ Marital Status _____

Occupation _____

Name _____ Bro/Sis/Step Age: _____

Where does he/she live? _____ Marital Status _____

Occupation _____

Name _____ Bro/Sis/Step Age: _____

Where does he/she live? _____ Marital Status _____

Occupation _____

Name _____ Bro/Sis/Step Age: _____

Where does he/she 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 Denominational Preference: _____

Church Presently Attending: _____

City: _____

Member (Yes or No): _____ Average # of times per month you attend: _____

Pastor: _____ Phone or Email: _____

Permission to contact him (Yes or 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: _____

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 that 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 ___
Liver problems ___
Kidney Problems ___
Head injury/concussion ___
Stroke ___
Seizures ___
Brain Tumor ___
Multiple Sclerosis ___
Parkinson's Disease ___
Blackouts ___
Amnesia ___
Tremors ___
Thyroid dysfunction ___
Diabetes ___
High Blood Pressure ___
Constant Hunger ___
Pneumonia ___

Hypoglycemia ___
Lung Problems ___
Allergies _____
Cancer ___
Incoordination ___
Anorexia or Bulimia ___
Visual Problems ___
Sensory distortions ___
Weakness ___
Fatigue ___
Heat/cold sensitivity ___
Bowel/bladder problems ___
Nausea or vomiting ___
Recent weight change ___
Impotence ___
Food cravings ___
Speech Problems ___

Menstrual irregularities ___
Hallucinations ___
Change in sexual drive ___
Problems walking ___
Unusual hair loss ___
Rashes ___
Memory Problems ___
Episodic disorientation ___
Personality change ___
Deja Vu ___
Changes in consciousness ___
Headaches ___
Dizziness ___
Stiff neck ___
Physical changes ___
Fever ___
Panic Attacks ___

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.)

Section VII – Presenting Struggles

What current struggles are you dealing with now that is prompting you to seek biblical counsel? Please be specific and open as possible. The more information given the sooner we will be able to address the specific struggles and seek change.

Other information that might be helpful for us to know about you: