Valley Hope Counseling Center
Personal Data Inventory

Name: ____ Today's date: ________________

Address: _______________________________________City_________________State_____Zip_______

Primary phone: _______________Secondary phone: _______________Email: ________________________

Date of Birth: ___________ Age: _____ Race: ______________Gender: __________ Pronouns: _______

Emergency Contact: _________________________ Phone: _________________ Relation: _____________

Family's Annual Gross Income: _____________________ Family Size: _______________

Employer: ____Occupation: ____________________________

Education (highest grade completed): __Elementary ___HS ___GED ___College ___Grad School

Marital Status: ___Single ___Living with partner ___Married ___Separated ___Divorced ___Widowed

Length of current relationship: ___________________________

Please list the names, ages, and relationship to you of all those in your current household: _________________

____

____

List any childhood/family history or other major life events that you feel may be relevant: ___________________

____

____

Rate your general physical health: _______Very good _______Good _______Average _______Poor

List any health or medical problems: ____

List any medications you are currently taking: ____

Name of physician or health care facility: ____

Have you had previous counseling or mental health treatment? _______ If so, where and when? ____________

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Please check any problem that you are currently experiencing or have experienced in the past.

Past	Recent	
_____	_____	Anxiety or feeling keyed up or on edge
_____	_____	Phobias or fears
_____	_____	Anxiety attacks or panic attacks
_____	_____	Excessive worry
_____	_____	Depressed mood
_____	_____	Frequent mood swings
_____	_____	Feelings of hopelessness
_____	_____	Low motivation
_____	_____	Fatigue/Low energy
_____	_____	Low self-esteem
_____	_____	Isolation from others
_____	_____	Tearful or crying spells
_____	_____	Difficulty remembering things
_____	_____	Flashbacks or Intrusive Thoughts
_____	_____	Sleeping too little or too much
_____	_____	Difficulty controlling anger
_____	_____	Eating too little or too much
_____	_____	Compulsive Behaviors (binge-eating, purging, shopping, exercise, etc.)
_____	_____	Repetitive Behaviors (Hand-washing, cleaning, counting, etc)
_____	_____	Overuse of alcohol
_____	_____	Overuse of drugs
_____	_____	Sexual impulsivity
_____	_____	Difficulty performing sexually
_____	_____	Suicidal thoughts
_____	_____	Thoughts of harming others
_____	_____	Violence towards others
_____	_____	Cutting or other self-harm
_____	_____	Loss (death, divorce, separation, etc.)
_____	_____	Being abused, mistreated, or neglected (physically, emotionally, sexually, etc.)
_____	_____	Problems with work
_____	_____	Relationship Problems
_____	_____	Parenting problems
_____	_____	Legal problems
_____	_____	Other, please list: ____
		____