**Valley Hope Counseling Center**

**Personal Data Inventory**

Please complete both sides of this form and return it to your counselor. The information requested on this form is intended for office use and is kept in your confidential record.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_OK to call? (Yes / No) Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call? (Yes / No)

Social security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to call? (Yes / No) Family’s Annual Gross Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education (highest grade completed) \_\_ Elementary HS GED College Grad School

Marital Status: Single Living with partner Married Separated Divorced Widowed

Length of current relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of marriage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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If you or your partner/spouse have children not living with you, please list their names, ages, and locations:

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

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If you or your spouse has been previously married, please specify who was married and the approximate dates of those marriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any childhood or family history that you feel may be relevant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Rate your general physical health: \_\_\_\_\_\_\_Very good \_\_\_\_\_\_\_Good \_\_\_\_\_\_\_Average \_\_\_\_\_\_\_Poor

Any recent weight changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any recent sleeping changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

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



**PROBLEM CHECKLIST**

Please check any problem that you are currently experiencing or have experienced in the past year. Your counselor will discuss these problems in more depth with you in the counseling session.

\_\_\_\_\_ Depression

\_\_\_\_\_ Anxiety or nervousness

\_\_\_\_\_ Alcohol abuse

\_\_\_\_\_ Intense anger/aggressive behavior

\_\_\_\_\_ Fears, phobias

\_\_\_\_\_ Irritability

\_\_\_\_\_ Financial problems

\_\_\_\_\_ Eating disorder/body image

\_\_\_\_\_ Relationship problems

\_\_\_\_\_ Severe mood swings

\_\_\_\_\_ Panic attacks (feeling as if you can’t breathe, racing heart beat, sweating, etc.)

\_\_\_\_\_ Decreased interest in usual activities

\_\_\_\_\_ Suicidal thinking

\_\_\_\_\_ Lack of concentration, indecision

\_\_\_\_\_ Hurting yourself, or thoughts of self-harm

\_\_\_\_\_ Drug abuse

\_\_\_\_\_ Racing thoughts or feeling too “hyper”

\_\_\_\_\_ Periods of extremely high energy with decreased need for sleep

\_\_\_\_\_ Issues related to being abused (physically, sexually, or emotionally)

\_\_\_\_\_ Abusing others

\_\_\_\_\_ Loss (death, divorce, separation, etc.)

\_\_\_\_\_ Work problems

\_\_\_\_\_ Temper problems

\_\_\_\_\_ Problems with sleep (sleeping too much or too little)

\_\_\_\_\_ Violence

\_\_\_\_\_ Thoughts of harming someone else

\_\_\_\_\_ Poor appetite

\_\_\_\_\_ Repetitive behaviors (hand washing, checking, counting, etc.)

\_\_\_\_\_ Problems with authority

\_\_\_\_\_ Arguing/conflict with others

\_\_\_\_\_ Sexual problems

\_\_\_\_\_ Social difficulties

\_\_\_\_\_ Legal problems

\_\_\_\_\_ Excessive worrying

\_\_\_\_\_ Parenting problems

\_\_\_\_\_ Thought disorganization, confusion

\_\_\_\_\_ Tiredness, low energy