Valley Hope Counseling Center
Personal Data Inventory

Name: _____ Today's date: _____

Address: _____City_____State_____Zip_____

Primary phone: _____ Secondary phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Gender: _____ Date of birth: _____ Age:_____ Family's Annual Gross Income: _____

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: _____ Date of marriage: _____

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

_____

_____

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

_____

_____

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: