ASAP
COUNSELING SERVICES

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ADULT PERSONAL DATA INVENTORY

Date Completed:	
Dates Revised:	

All questions contained in this questionnaire are strictly confidential and will only be shared with your counselor.

DEMOGRAPHIC INFORMATION:			
Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Address: *(City, ST, ZIP):*			
Phone		**Email:**	
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
How did you hear about ASAP Counseling Services:			
Occupation:			
Spouse's Name (If applicable):			
Spouse's Occupation (If applicable):			

Children (ages if they are living in the home):

Name	Age	Step-child *(check if applicable)*
1) _____	_____	☐Yes ☐No
2) _____	_____	☐Yes ☐No
3) _____	_____	☐Yes ☐No
4) _____	_____	☐Yes ☐No

Emergency Contact Information

Name:	Phone:	Address:

Presenting Problem (why are you here):

Attempted Solutions & Results:
Goal(s) for Counseling:
Strengths:
Hobbies/Interests:

ADULT PERSONAL DATA INVENTORY (Page 2)

Psychosocial Information		
Who makes up your support system?		
Do you believe this support system is adequate?	☐ **Yes** ☐ **No**	
Why is this support system adequate *(if you checked Yes)*?	**Why is this support system <u>not</u> adequate *(if you checked No)*?**	
How important is faith and belief in God to you and your family?		
What do you believe about the following:		
God		
Jesus		
Holy Spirit		
What sin do you deal with regularly and how does it show up in your life?		
Church Affiliation:		
Pastor's Name:		
Counseling History		
Have you previously been in counseling?	☐ **Yes** ☐ **No**	
If yes, please provide:		
Reason:		
Agency:		
Counselor Name:		
Counselor Phone:		
Permission to contact counselor?	☐ **Yes** ☐ **No**	
Current Medications		
Medication Name	Purpose	

Please turn to next page

Past Psychiatric History (if applicable)	
List any admissions or outpatient therapy:	
Diagnoses:	
Medications used/effectiveness:	
Family history of mental illness:	
Family history of suicide:	

Concurrent stressors and symptoms: *(check all appropriate answers in each category)*		
☐ Depressed Mood	☐ Appetite Changes	☐ Sleeping Changes
☐ Feelings of Guilt	☐ Fatigue/Low Energy	☐ Poor Concentration
☐ Irritability/Anger	☐ Substance Abuse	☐ Anxiety
☐ Hopelessness	☐ Physical Complaints	☐ Social Isolation
☐ Feelings of Worthlessness	☐ Loss of Pleasure in Hobbies/Interests	☐ Weight Loss
☐ Weight Gain	☐ Intense Crying	☐ Recurring Thoughts/Images
☐ Feelings of Panic	☐ Loneliness	☐ Memory Impairment
☐ Disorganized Thoughts	☐ Other: _____	

Concurrent stressors and symptoms (Personal/Relational):		
☐ Anger/Difficulty controlling temper	☐ Medical Problems	☐ Financial Problems
☐ Unemployment	☐ Employment Stress	☐ Lack of Emotional Support
☐ Infidelity	☐ History of Abuse	☐ Marital Conflict
☐ Other: _____		

Concurrent stressors and symptoms (Life Adjustment):		
☐ Divorce or Separation	☐ Newly Married or Remarried	☐ Stepfamily with children
☐ Moving to New Location	☐ Parenting a Newborn	☐ Being a Single Parent
☐ Addition of a Parent to House	☐ Starting a New Job	
☐ Other: _____		

Concurrent stressors and symptoms (Family):	
☐ Custody or Visitation Problems	☐ One or more Family Members not Getting Along
☐ Major Difficulties with child or teen	☐ Children having Difficulty with Divorce or New Marriage
☐ Children having Difficulty with Loss of Loved one	
☐ Other: _____	