


# Timberlake Biblical Counseling and Training Center



## Personal Data Inventory

Client #: \_\_\_\_\_

Timberlake Biblical Counseling and Training Center  
Dr. Bryan Ferrell, Executive Director  
Dr. Mark Hager, Director



## Personal Data Inventory

### I. GENERAL INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Date \_\_\_\_\_  
 Street Address \_\_\_\_\_ Apartment/Unit # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Permission to leave a message?  Yes  No  
 Email \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_/ Age \_\_\_\_\_ Gender  Male  Female  
 Permission to contact via email?  Yes  No Education (highest level completed) \_\_\_\_\_  
 Degree/Certificates \_\_\_\_\_ Other Training \_\_\_\_\_  
 Employer (current or last) \_\_\_\_\_ Position \_\_\_\_\_ Years Employed Here: \_\_\_\_\_

### II. MARITAL STATUS (CHECK ALL THAT APPLY)

Single  Dating  Engaged  Married  Divorced  
 Separated  Widowed  Remarried  Living together & unmarried  
*I consider myself:*  Heterosexual  Bisexual  Homosexual  Not sure

### III. HEALTH INFORMATION

*My Health Is:*  Very Good  Good  Average  Less-than-average  Poor

Current health issues: \_\_\_\_\_

Primary Physician (name & facility) \_\_\_\_\_

Date of Last Medical Examination \_\_\_\_\_ Report \_\_\_\_\_

Are you currently taking medications?  Yes  No If yes, please list below.

Medication	Dosage	Frequency	Reason for use

Have you used drugs for other than medical purposes?  Yes  No Which drugs? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No How much in one week? \_\_\_\_\_

Do you smoke?  Yes  No What? \_\_\_\_\_ How often? \_\_\_\_\_

Approximately how many hours of sleep do you get each night? \_\_\_\_\_

When do you normally: go to bed? \_\_\_\_\_ Fall asleep? \_\_\_\_\_ Wake up? \_\_\_\_\_ Get out of bed? \_\_\_\_\_

If there is a length of time between going to bed and falling asleep, what do you do during that time? \_\_\_\_\_

If there is a length of time between your waking up and getting out of bed, what do you do during that time? \_\_\_\_\_

Describe any recent changes in sleep habits: \_\_\_\_\_

Daily caffeine consumption: \_\_\_\_\_

Recent weight changes:  Gained  Lost Reason for change: \_\_\_\_\_

#### IV. WOMEN ONLY

Have you had any menstrual difficulties?  Yes  No Explain: \_\_\_\_\_

Do you experience tension, tendency to cry, or other symptoms prior to your cycle?  Yes  No Explain: \_\_\_\_\_

Do you think your responses or reactions are due to menstrual difficulties?  Yes  No

#### V. FAMILY HISTORY

Name of Father: \_\_\_\_\_ Living?  Yes  No Name of Mother: \_\_\_\_\_ Living?  Yes  No

Describe parent's involvement in your life: \_\_\_\_\_

Parents (check all that apply)  Never Married  Married  Separated  Divorced  Remarried

Your age when parents separated: \_\_\_\_\_ Your age when parents divorced: \_\_\_\_\_

Were you raised by anyone other than your biological parents?  Yes  No If so, please explain \_\_\_\_\_

List your siblings from oldest to youngest, including yourself. Mark step-siblings with an asterisk (\*) \_\_\_\_\_

#### VI. MARRIAGE INFORMATION

Name of Spouse \_\_\_\_\_ Age \_\_\_\_\_ Religion \_\_\_\_\_

Education \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Wedding date \_\_\_\_\_ Age when married: You \_\_\_\_\_ Your Spouse \_\_\_\_\_

Length of dating relationship \_\_\_\_\_ Length of engagement relationship \_\_\_\_\_

Briefly describe your relationship: \_\_\_\_\_

Are you currently separated?  Yes  No Separation Date \_\_\_\_\_

Have you ever been separated?  Yes  No How many times? \_\_\_\_\_

How long was each separation? \_\_\_\_\_

Reason for separation(s)? \_\_\_\_\_

Has either of you ever filed for divorce?  Yes  No When? \_\_\_\_\_ Who? \_\_\_\_\_

Has either of you been married before? Husband  Yes  No How many? \_\_\_\_\_

Wife  Yes  No How many? \_\_\_\_\_

If you were married before, what is the reason(s) the marriages(s) ended? \_\_\_\_\_

### VII. CHILDREN INFORMATION

PM*	Name	Age	Sex	Living? Yes or No	Education in years	Marital Status	Living with you? Yes or No
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							

\*Check column if child is by previous marriage of either spouse.

Other Pregnancies (that you fathered or carried): \_\_\_\_\_ # of miscarriages: \_\_\_\_\_ # of abortions: \_\_\_\_\_

### VIII. RELIGIOUS BACKGROUND

What religion do you associate with: \_\_\_\_\_  Non-religious

Denomination/sect preference, if any: \_\_\_\_\_

Church presently attending: \_\_\_\_\_

Church Address: \_\_\_\_\_ Pastor's Name \_\_\_\_\_

Are you a member?  Yes  No Describe your current involvement: \_\_\_\_\_

How long have you attended? \_\_\_\_\_ Does your family attend with you?  Yes  No

Does your pastor know of your decision to seek biblical counseling?  Yes  No Permission to consult with pastor?  Yes\*  No

Have you ever been/are you under church discipline?  Yes  No If so, what church? \_\_\_\_\_

Names of previous churches and reason for leaving: \_\_\_\_\_

Baptized?  Yes  No If you were baptized after infancy, what was your age? \_\_\_\_\_

Father's Religion: \_\_\_\_\_ Mother's Religion: \_\_\_\_\_

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Lynchburg, VA., 24502

[counseling@timberlakebaptist.org](mailto:counseling@timberlakebaptist.org) 434.237.6464

\* If yes, please complete the CC109 – Information Release Form

Describe your own understanding of God: \_\_\_\_\_

Explain who Jesus is. \_\_\_\_\_

What is the Bible? \_\_\_\_\_

Do you believe the Bible is the Word of God and has authority in your life?  Yes  No

Do you have a relationship with Jesus Christ? If so, how did this relationship come about? \_\_\_\_\_

Are you forgiven by God?  Yes  No  Not sure      Would you go to heaven if you died?  Yes  No  Not sure

Do you pray to God?  Never  Occasionally  Often      How frequently do you read the bible?  Never  Occasionally  Often

Bible reading or prayer with your spouse and children?  Never  Occasionally  Often

Please explain any recent changes in your spiritual life: \_\_\_\_\_

God's expectations of you currently: \_\_\_\_\_

Greatest spiritual need today: \_\_\_\_\_

**IX. PROFESSIONAL SERVICES**

\*Please list all past and current counselors, therapists, psychologists, and psychiatrists you have seen.

<u>Professionals Name</u>	<u>Dates: Start to Finish</u>	<u>Medication Prescribed</u>	<u>Outcome</u>

**X. BRIEFLY ANSWER THE FOLLOWING QUESTIONS:**

1. What is the problem or concern that brings you here today?

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2. What have you done about this problem?

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3. What are your expectations from counseling?

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4. Is there any other information we should know about?

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I have read and understand the counseling information provided and filled out this form truthfully and to the best of my ability. I understand that the staff counselors are not psychologists or psychiatrists, and may not be state licensed under the state of Virginia statutes. I understand that the counsel is foundationally biblically based. I also understand that:

- 1) Most of the counselors will possess a biblical certification from various certifying agencies, and some may possess additional higher education in counseling.
- 2) Some counselors may be assisted by intern counselors who are working toward their biblical counseling certification (these are students trained and spiritually prepared to counsel).
- 3) Some counselors may be student counselors that are in their biblical certification process and specifically requested by the counselee.

I also understand that confidentiality of my problem(s) and circumstances will be respected by the counselor(s) and the counseling staff of Timberlake Biblical Counseling and Training Center, or the Elders and/or Pastoral staff of Timberlake Baptist Church. I further understand and agree that intern counselors may be required to discuss my problem(s) with the counseling director and/or another member of the staff when needed. My signature below affirms that I have read and agree with the above consent and statement.

Name: \_\_\_\_\_  
(Clearly print full name)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Counselor: \_\_\_\_\_