

NEW DAY CHRISTIAN COUNSELING

420 University Ave., Suite 206
Charlottetown, PE C1A 7Z5 Canada
Phone: (902) 367-1939
Email: tom@newday4me.ca

www.newday4me.ca

CONFIDENTIAL PERSONAL INVENTORY

(If you are filling this document out by hand, please use black ink.)

BASIC INFORMATION

Name: _____ Phone: _____ Age: _____

Address: _____

_____ Email: _____

Skype™ contact information: _____

What counselors/therapists have you previously seen? _____

Highest level of education: _____ Occupation: _____

PRESENTING PROBLEM(S)

1. Describe the problem(s) or issue(s) that brings you to counseling. _____

2. Imagine that problem(s) or issue(s) resolved. What should life look like without it?

RELIGIOUS HISTORY

- 1. Past church affiliation(s): _____
- 2. Present church affiliation: _____
- 3. Have you placed your faith in the Gospel and received Christ as Savior? Yes No
- 4. Are you presently attending church services? Yes No
- 5. Do you struggle with doubts about your eternal salvation? Yes No
If yes, please explain. _____

- 6. Are there any situations or people in your religious/spiritual/church-life that relate to the problem that brings you to counseling? Yes No
If yes, please explain. _____

FAMILY OF ORIGIN

- 1. List your parents and siblings by order of age (include yourself).
Parents: _____
Siblings: _____

- 2. Were you adopted, raised in a blended home (with step-parent or siblings), or placed in the foster system? No.
If yes, briefly describe any thoughts or feelings related to this. _____

- 3. Would you describe your upbringing as overly-permissive, permissive, average, strict or overly-strict? Describe any thoughts or feelings related to this. _____

- 4. How did your parents speak and act toward one another? _____

- 5. Was either of your parents ever unfaithful to the other? Yes No
- 6. Are your parents married, separated or divorced?
If more complex than this, please provide additional details. _____

7. How did your parents speak and act toward you? _____

8. Were there any addictions or substance abuse problems in your home of origin?

Yes No

If yes, please describe. _____

9. Was there a sense of security during your upbringing? Yes No

If not, please explain. _____

10. Was there any emotional, physical, or sexual abuse in the home of origin? Yes No

If yes, please describe. _____

11. Is there any history of physical or mental illness in your family of origin? Yes No

If yes, which? _____

12. Describe the circumstances around which you left home. _____

13. Describe any significant conflicts/problems in any of your relationships with the members of your family of origin. _____

14. In your opinion, and related to your counseling issue(s), what are the most important things that I should know about your family of origin? _____

PERSONAL HISTORY

1. Are there any situations or people at your place of work (or school) that contribute to the issue that brings you to counselling? Yes No

If yes, please explain. _____

2. Do you have any relational patterns or behaviors that cause problems, or generally receive negative reactions from people? Yes No

If yes, please describe. _____

3. Do you struggle with addictions (shopping, eating, smoking, drinking, gambling, street or prescription drugs, pornography, etc.)? Yes No

If yes, which? _____

4. Have you experienced any significant trauma? That is, have you been in an accident, been the victim of terror, violence or disaster, been raped, witnessed atrocities, or experienced any other situation of great fear? Yes No

If yes, please describe. _____

5. Have you ever been touched or used sexually in an inappropriate way? Yes No

If yes, please explain. _____

6. In your opinion, and related to your counseling issue(s), what are the most important things that I should know about your personal history? _____

MARITAL/RELATIONAL HISTORY

1. Provide the basic details of your present relationship, including children and ages.

2. Provide basic information related to prior marriages or significant relationships.

3. Have you ever experienced an abortion, miscarriage, stillbirth, or death of a child?

Yes No

If yes, please clarify. _____

4. Describe any significant conflicts/issues with your spouse/partner. _____

5. Describe any significant conflicts/issues with your children. _____

6. Describe any stress-increasing family issues (infertility, special needs child, care for elder, occupational insecurity, child-behavior problems, domestic violence or abuse, etc.).

7. Describe any significant conflicts/issues related to how your current family relates with your family of origin or with that of your spouse. _____

8. Describe any “interpersonal relational dynamics” (how you interact with one another) that contribute to relationship or family problems (Yours or your partner’s). _____

9. In your opinion, and related to your counseling issue(s), what are the most important things that I should know about your marital/relational history? _____

MENTAL/EMOTIONAL HEALTH

1a. Which of the following emotions do you struggle with?

- | | | |
|---|---|--|
| <input type="checkbox"/> Anger or rage | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Relational discomfort | <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fear of illness or death | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bitterness |
| <input type="checkbox"/> Rejection | <input type="checkbox"/> Fear of rejection | <input type="checkbox"/> Feeling debased |
| <input type="checkbox"/> Self-contempt | <input type="checkbox"/> Other-focused contempt | <input type="checkbox"/> Remorse |
| <input type="checkbox"/> Emotional numbness | <input type="checkbox"/> Jealousy or envy | <input type="checkbox"/> Stress/tension |
| <input type="checkbox"/> Emotional instability | <input type="checkbox"/> Emotional breakdown | <input type="checkbox"/> Pride |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Social fears | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Humiliation or shame | <input type="checkbox"/> Grief or sorrow | <input type="checkbox"/> Dismay |
| <input type="checkbox"/> Loss of interest or pleasure | <input type="checkbox"/> Shyness | <input type="checkbox"/> Restless/wound up |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Dissatisfaction with life | <input type="checkbox"/> Feeling hurt |
| <input type="checkbox"/> Fearful dependence on others | <input type="checkbox"/> Delirium/fogginess | <input type="checkbox"/> Timidity |
| <input type="checkbox"/> Sense of detachment | <input type="checkbox"/> Suspiciousness/mistrust | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Emotional avoidance | <input type="checkbox"/> Excessive emotionality | <input type="checkbox"/> Hatred |
| <input type="checkbox"/> Hunger for admiration | <input type="checkbox"/> Over-care for others | <input type="checkbox"/> Lack of empathy |
| <input type="checkbox"/> Hypersensitive to criticisms | <input type="checkbox"/> Excessive need to be loved | <input type="checkbox"/> Overwhelmed |
| <input type="checkbox"/> Pessimism | <input type="checkbox"/> Brooding over the past | <input type="checkbox"/> Frustration |
| <input type="checkbox"/> Powerlessness | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Insecurity |
| <input type="checkbox"/> Performance anxiety | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Inadequacy |
| <input type="checkbox"/> Specific phobia: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

1b. Comment on those from the list that you believe have the greatest impact on you, or are of greatest importance to the issue(s) that brings you to counseling. _____

2. Have you ever been diagnosed with a mental disorder? Yes No
If yes, which, when, and by whom? _____

3. Do you have trouble sleeping, frequent nightmares, or other disturbances? Yes No
If yes, which? _____

4. Are you using any medications for psychological reasons? Yes No
If yes, which? _____

