INDIANA BIBLICAL COUNSELING CENTER

Confidential Client Inventory

Personal Information

Name:_____ Date:_____

Address:_____ City: _____ State:____ Zip:_____

Home Phone:_____ Cell Phone: _____

Email_____

Marital Status: _ Single _ Married _ Divorced Age: _____

Previous History of Marriage/Divorce:_____

Do you have any children? How many? _____ Ages: _____

What is your occupation? _____

Home Church:_____ Pastor: _____

Reason for Counseling:

_____

_____

_____

_____

How do you feel about receiving counseling?

_____

_____

_____

Family History

Briefly describe your parents' Christian experience.

_____

_____

_____

Briefly describe the relationship between your parents?

_____

_____

_____

Check the word(s) that describe the atmosphere in your home during your growing up years?

_ Loving
_ Abusive
_ Neglectful
_ Nurturing
_ Permissive
_ Rigid
_ Tense
_ Legalistic
_ Controlling
_ Fun
_ Encouraging
_ Fearful
_ Caring
_ Crazy
_ Safe

Describe your relationship with your parents when you were growing up?

Faith Assessment

When did you recognize your need for Jesus Christ to forgive your sin? Describe your experience?

If today was your last day to live, where would you spend eternity?

If God were to ask you why should I allow you into Heaven, what would you say?

Are you plagued with doubts concerning your salvation? _ Yes _ No

Are you currently attending a local church where the Bible is preached, and do you regularly support it with your time, talent, and treasure? _ Yes _ No

Are you presently enjoying fellowship with other believers, and if so where and when?

In your minds eye, if Jesus were looking at you, what facial expression would He have when He looks at you?

Why would He be looking at you that way?

Do you have regular quiet time and Bible study with God? _ Yes _ No

Do you find prayer difficult mentally? _ Yes _ No

Have you memorized or meditated on Scripture? _ Yes _ No

Medical History

Do you have with any major health problems? If yes, explain.

Have you been diagnosed with a psychological condition? If yes, explain:

Are you currently taking any prescription medications? _ Yes _ No

(If yes, list medications.)

Have you ever been hospitalized for emotional or psychological problems? If yes, explain.

Have you ever experienced any type of trauma (i.e. physical, emotional, or sexual history of abuse, involvement in a severe accident, death of family member, etc)? Explain.

Spiritual and Emotional Conflicts

Check any of the following with which you are struggling.

_ Depression	_ Dissociation	_ Bitterness
_ Inadequacy	_ Sadness (Grief)	_ Pride
_ Anxiety	_ Anger	_ Sexual Immoral Behavior
_ Fear	_ Negative Thoughts	_ Rebellion
_ Panic Attacks	_ Insecurity	_ Perfectionism
_ Blasphemous Thoughts	_ Stressed Out	_ Legalism/Performance Based
_ Lustful Thoughts	_ Hopeless Despair	_ Boundaries
_ Worry	_ Shame / Guilt	_ Unhealthy Relationships
_ Obsessive/Compulsive Thoughts	_ Suicidal Thoughts	_Rejection

What are the greatest concerns in your life?

What are your greatest needs in your life?

If married, how do you feel about the state of your marriage?

If single, how do you feel about being single?

Is there any other information we should be aware of that could be helpful in your counseling?