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

Previous History of Marriage/Divorce:__________________________________

Do you have any children? How many? ________ Ages: ______________________

What is your occupation? ____

Home Church:__________________________ Pastor: __________________

Reason for Counseling:-

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Family History

Briefly describe your parents' Christian experience. ___________________________

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Are your parents presently ☐married or ☐divorced? (Check one)

Was your father clearly the head of the home? ☐Yes ☐No

Briefly describe the relationship between your parents?________________________

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Were you adopted? ☐Yes ☐No

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

☐ Loving	☐ Rigid	☐ Encouraging
☐ Abusive	☐ Tense	☐ Fearful
☐ Neglectful	☐ Legalistic	☐ Caring
☐ Nurturing	☐ Controlling	☐ Crazy
☐ Permissive	☐ Fun	☐ 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 were 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?

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

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Why would He be looking at you that way?______________________________

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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.

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Have you been diagnosed for any medical or psychological condition? If yes, explain:

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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 have struggled or are struggling.

- ☐ Depression
- ☐ Inadequacy
- ☐ Fantasy
- ☐ Dizziness
- ☐ Panic Attacks
- ☐ Blasphemous Thoughts
- ☐ Lustful Thoughts
- ☐ Worry
- ☐ Obsessive Thoughts
- ☐ Memory Loss
- ☐ Sadness
- ☐ Inferiority
- ☐ Doubts
- ☐ Insecurity
- ☐ Compulsive Thoughts

Check any of the following issues where you feel you struggle personally:

Rejection ☐
Pride ☐
Legalism/Performance Based Acceptance ☐
Fear/Anxiety ☐
Sexual Immorality ☐
Bitterness ☐
Rebellion ☐
Negative Thoughts ☐
Guilt ☐
Unhealthy Relationships ☐

Temporal Values ☐
Cult/Occult ☐
Generational Weaknesses/Sins ☐
Abuse ☐
Addictions ☐
Anger ☐
Spiritual Oppression ☐
Personality Disorder ☐

What are your greatest concerns in your life?

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What are your greatest needs in your life?

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If married, how do you feel about the state of your marriage?__________________________
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If single, how do you feel about being single?______________________________________
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Is there any other information we should be aware of that could be helpful in your counseling?