

# PARKSIDE CHURCH

7100 Pettibone Road, Chagrin Falls, OH 44023

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www.parksidechurch.com

## BIBLICAL COUNSELING INVENTORY

Full Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Are you currently employed? YES NO

Business Phone: \_\_\_\_\_

Last education completed:

GED  High School  Some college  College  Graduate/Masters work

Current Marital Status:

Single  Married  Separated  Divorced  Widowed

Referred here by: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

How do you know this person? \_\_\_\_\_

Please mark available times to meet with counselor:

Morning  Afternoon  Evening  
 Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

### Marriage & Family Information

Name of Spouse: \_\_\_\_\_ Spouse's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is his/her address same as above? YES NO

If not: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_ Anniversary: \_\_\_\_/\_\_\_\_/\_\_\_\_

Ages when married: \_\_\_\_\_ HUSBAND \_\_\_\_\_ WIFE

Is your spouse willing to come in for counseling? YES NO

Has your spouse ever been divorced? YES NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been divorced/separated?                      YES                      NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Name	Age	Gender	Marital Status

*\*please mark children from previous marriages/relationships*

### Religious Background

Church and denomination attended in childhood: \_\_\_\_\_

Do you have a denominational preference? \_\_\_\_\_

How long have you attended Parkside Church? \_\_\_\_\_     Bainbridge Campus     Green Campus

What ministries are you currently involved in at Parkside Church? \_\_\_\_\_  
\_\_\_\_\_

Church attendance per month (*circle one*)                      0   1   2   3   4   5   6   7   8+

Are you a member of Parkside Church?                      YES                      NO

Is your spouse a member of Parkside Church?                      YES                      NO

Have you been baptized?                      YES                      NO

Does your spouse attend Parkside?                      YES                      NO

If no, does he/she attend elsewhere?                      YES                      NO

Would you describe yourself as a believer?                      YES                      NO

What is your basis for answering this question as you did? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What changes took place in your life after becoming a believer? \_\_\_\_\_

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Please write out what you believe the gospel is: \_\_\_\_\_

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Do you read the Bible?                      NEVER              OCCASIONALLY              OFTEN

Do you pray?                                      NEVER              OCCASIONALLY              OFTEN

Do you have family devotions?              NEVER              OCCASIONALLY              OFTEN

Do you pray with your spouse?              NEVER              OCCASIONALLY              OFTEN

Do you pray with your children?              NEVER              OCCASIONALLY              OFTEN

Give a brief overview of what your personal devotions looks like: \_\_\_\_\_

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

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### **Medical & Health Information**

Have you received Biblical Counseling at Parkside Church before?      YES      NO

If so, who was your counselor? \_\_\_\_\_

Have you received counseling or therapy outside of Parkside?      YES      NO

Please list below.

<b>Counselor/Psychologist/ Psychiatrist</b>	<b>Duration</b>	<b>Medication prescribed?</b>	<b>Diagnosis/ Outcome</b>

Please list 6 words to describe your personality:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent weight change? \_\_\_\_\_

Average number of hours of sleep per night? \_\_\_\_\_

Each night, at what time do you: go to bed \_\_\_\_\_ fall asleep \_\_\_\_\_ wake up \_\_\_\_\_

Describe any changes in your sleep patterns \_\_\_\_\_

Health	VERY GOOD	GOOD	AVERAGE	DECLINING
Hearing	VERY GOOD	GOOD	AVERAGE	DECLINING
Sight	VERY GOOD	GOOD	AVERAGE	DECLINING
Appetite	VERY GOOD	GOOD	AVERAGE	DECLINING
Energy	VERY GOOD	GOOD	AVERAGE	DECLINING

Are you presently taking any medication? YES NO

Medication	Dosage	Side-Effects	How long have you been taking this?

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last medical exam: \_\_\_\_\_

Have you ever used drugs for other than medical purposes? YES NO

If yes, please explain: \_\_\_\_\_

Do you drink alcoholic beverages? YES NO How often? \_\_\_\_\_

Do you smoke? YES NO How much? \_\_\_\_\_

Would you be willing to release medical and previous counseling information to your counselor in the event that it is necessary? YES NO

Did you read the counseling cover letter? YES NO

Did you read the Biblical Discipleship & Hold Harmless Agreement? YES NO

