BIBLICAL COUNSELING

Please complete this inventory carefully and thoroughly.

Personal Identification

Name:_____Birth Date: _____

Address:_____Zip Code: _____

Age:_____Gender:_____

Marital Status (circle): Single Engaged Married Separated Divorced Widowed

Home Phone:_____Cell Phone: _____

Spouse if applicable: _____

Problem Checklist: Please rate how these items impact your life

(blank) = no significant impact; 1 = mild impact; 2 = moderate impact; 3 = severe impact

_____ Anger	_____ Discouraged/Downcast	_____ Memory
_____ Anxiety	_____ Drunkenness	_____ Moodiness
_____ Apathy	_____ Envy	_____ Overwhelmed
_____ Appetite	_____ Fear	_____ Perfectionism
_____ Bitterness	_____ Finances	_____ Pornography
_____ Change in lifestyle	_____ Gluttony	_____ Procrastination
_____ Children	_____ Guilt	_____ Rebellion
_____ Communication	_____ Health	_____ Sexual Immorality
_____ Conflict (fights)	_____ Homosexuality	_____ Sex (in marriage)
_____ Control	_____ Impotence	_____ Sleep
_____ Deception	_____ In-laws	_____ Spouse Abuse
_____ Decision Making	_____ Laziness	_____ Time Usage

_____ Depression	_____ Loneliness	_____ Weary
_____ Disciplined Living	_____ Lust	_____ Other
_____ Disorganization	_____ Marriage	

Briefly Answer The Following Questions

1. What is the main problem as you see it? What brings you here?

2. Is there any other information that we should know?