# Crossed-Up Counseling Ministry

## Client Inventory Form

Please complete this inventory as carefully as possible. Answer each item that applies to you. All information you provide will be treated confidentially and will become part of your record. If you have a question about a particular area, please put a mark by it and ask your counselor when it is complete.

**CLIENT INFORMATION**

Name: _____ Date: _____

Home Address: _____

_____

Phone (Home) _____ (Work) _____ (Cell) _____

Sex: _____ Date of Birth: _____ Age: _____

E-Mail Address: _____

Occupation: _____ Hours per Week: _____
Employed by:

Referred Here by: _____ Phone: _____
Referral's Address: _____

Emergency Contact: _____ Phone: _____
Contact's Address: _____

**MARRIAGE INFORMATION** (Circle One)

**Single** **Engaged** **Married** **Separated** **Divorced**

**Remarried** **Living Together** **Widowed**

Please list your relationships below. List your children beginning with the oldest.
(Place a check by the child's name if from a previous marriage.)

| **Relationship** | **Name** | **Age** | **Grade/Occupation** |
|---|---|---|---|
| SPOUSE | | | |
| EX-SPOUSE | | | |
| CHILDREN | | | |
| (or siblings | | | |
| IF under 18) | | | |
| | | | |
| MOTHER | | | |
| FATHER | | | |

What Year Married?: _____ How Long Did You Date?: _____
How Did You Meet?: _____
Did Your Parents Approve of Your Marriage?: _____
Spouse's Parents?: _____
Have You Ever Been Married Before?: _____
Number of Divorces?: _____ How Long Divorced?: _____

## FAMILY INFORMATION

(Circle One)

Father Living?: Yes No Mother Living? Yes No

If so, where?

What kind of relationship do/did you have with your father? (Circle One)

**Excellent Good Fair Poor NonExistent**

What kind of relationship do/did you have with your mother? (Circle One)

**Excellent Good Fair Poor NonExistent**

Did anyone else have a key role in your upbringing? (If so, who and why):

How many children are/were in your family? (Brothers and Sisters) _____

What child are you by number? (Circle One)

**Oldest 2nd 3rd 4th 5th 6th Youngest Other**

Do you feel like you have have adequate social support? ___Yes ___No

Describe your current support system?

## EDUCATION

Highest Level/Grade of Education Completed:

**___Non Complete ___High School ___Some College ___AA Degree**

**___College (Major:_____) ___Graduate (Major:_____)**

How well did you do in elementary school?

How well did you do in High School?

How well did you do in College?

How well did you do in Graduate School?

## RELIGION/FAITH

Religious Affiliation:

Place of Worship:

Circle Your Level of Church Activity: **___Active ___Inactive**

Briefly Describe how important your faith is to you:

Are you open to a Christian based counseling approach? ___Yes ___No

Do you want the counselor to pray with you? ___Yes ___No

**HEALTH**

Health Status: __Excellent __Good __Average __Poor __Very Poor

Height: _____ Weight: _____

Have you **gained** or **lost** any weight in the last six months? (Circle One) How much?

Describe any physical problems you have that require medication of physical care:

Are you currently under a doctor's care? _____

(If yes, please describe) _____

Physician's Name: _____ Address: _____

If you are currently taking any medication please complete below:

| **Name of Medication** | **Dosage** | **Date Prescribed** | **By Who** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever used drugs other than for medical purposes? _____

(If yes, what and when) _____

Please describe your use of alcoholic beverages:

**___Never** **___1-4 Times a Year** **___1-2 Times a Month**

**___1-2 Times a Week** **___4 Times a Week** **___Daily**

What medical and emotional problems existed in your family in which you grew up? _____

**Substance Abuse History**

Have you or a household member had any history of substance abuse (current or past)? ___Yes ___No

Check one: ___Self ___Household Member ___Both

Please explain _____

**Abuse History**

Have you or a household member experienced current or past emotional, physcial, or sexual abuse? ___Yes ___No

Check one: ___Self ___Household Member ___Both

Explain _____

**Trauma History**

Have you or a household member had a history (recent or past) of any trauma/traumatic events in your life? ___Yes ___No

Check one: ___Self ___Household Member ___Both

Please explain _____

**PREVIOUS COUNSELING HISTORY**

Have you previously had counseling/therapy? ___Yes ___No

When? _____

With Whom? _____ For How Long? _____

What do you feel was the outcome? _____

Why did you stop? _____

**PRESENTING PROBLEM(S)**

In your own words, briefly describe the main problem that prompted you to seek counseling at this time: _____

How long have you faced these problem? _____

Have there been times when the problems got better or disappeared? _____

___Yes ___No

If so, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? ___Yes ___No

When? _____

What made it bad? _____

Are there other people who play a role in: ___ Causing your problem?
___ Helping your problem?

Briefly explain: _____

Please check any of the following that are currently troubling you. Put **two** checks by those items that are most important. You may add any comments you would like:

___ Abortion/Adoption
___ Adjustment Problems
___ Anger/Temper
___ Anxiety (worry)
___ Apathy (the "blahs")
___ Assertiveness
___ Bitterness (Resentment)
___ Breathing Difficulty
___ Change of Lifestyle
___ Child Abuse
___ Children (Discipline)
___ Children (School)
___ Communication
___ Concentration
___ Confusion
___ Death of Loved One
___ Dependent On Others
___ Depression
___ Divorce
___ Dizziness
___ Eating Problems
___ Envy (Jealousy)
___ Exhaustion
___ Failure
___ Family Conflict
___ Family Violence
___ Father
___ Fatigue
___ Fear
___ Finances
___ Forgiveness
___ Frustration
___ Guilt
___ Health
___ Headaches
___ Homosexuality
___ Honesty
___ Impotence
___ Inability to Relax
___ In-Laws
___ Irritability
___ Loneliness
___ Loss of Interest
___ Loss of Pleasure
___ Lust
___ Mother
___ Marriage
___ Memory Difficulty
___ Muscle Tension
___ Occupation Issue
___ Opposite Sex
___ Over activity
___ Perfectionism
___ Pride
___ Rape
___ Rebellion
___ Rejection
___ Religion/Spiritual Issues
___ Repetitive Ideas
___ School Problems
___ Separation
___ Sex
___ Sexual Abuse
___ Shy/Awkward
___ Single Parenting
___ Sleep Problem
___ Spouse Abuse
___ Stomach/GI Disturbance
___ Stress
___ Substance Abuse
___ Substance Abuse in Family
___ Suicidal Thoughts
___ Suspiciousness
___ Troubling Memories
___ Troubling Habit
___ Trust
___ Underactivity
___ Unfairly Treated
___ Unusual Experiences
___ Wish To Hurt Someone
___ Withdrawal

How did you hear about this Crossed-Up? _____