



MAPS Counseling Services

Personal Information Form

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Keene NH 03431
603-355-2244

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Peterborough, NH 03458
603-924-2240

Fax: 603-355-2299

INSTRUCTIONS: This confidential form begins an open-ended dialogue with your therapist. Please carefully & clearly complete both sides.

PERSONAL INFORMATION

Today's Date _____

Your Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Social Security No.: _____

Phones: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Sex: M F Citizenship: US Other: _____

Marital Status: Single? Married? Partnered / Living together? Separated / Living apart? Divorced? Widowed?

Highest level of education completed: _____

Military history (branch & years of service): _____ Check if none

Occupation: _____ Employer: _____

List current legal issues: _____

HEALTH INSURANCE INFORMATION *If you have no health insurance, check here*

Medicaid ID No: _____ Medicare ID No: _____

Name of Insurance: _____ ID No.: _____ Group No.: _____

Name of Subscriber: _____ Subscriber's Social Security Number: _____

Subscriber's Employer: _____ Client's Relationship to the subscriber: _____

HEALTH INFORMATION

Your Primary Care Physician: _____ Location: _____ Phone No.: _____

Other Physicians: _____

How do you rate your overall physical health and fitness? Very good Good Average Poor / Declining

Have you seen a physician in the past 6 months? Yes No If yes, specify the reasons: _____

What medicines or supplements do you take regularly or occasionally (including dosages)? _____

Have you had any current or past experience with the following:

	Yes	No		Yes	No		Yes	No
Eating problems?	<input type="checkbox"/>	<input type="checkbox"/>	Developmental disability?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Illness?	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Remorse or guilt after drinking or using drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Sexual concerns?	<input type="checkbox"/>	<input type="checkbox"/>	Previous counseling?	<input type="checkbox"/>	<input type="checkbox"/>	Attempts to reduce your alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
Low energy?	<input type="checkbox"/>	<input type="checkbox"/>	Prescribed psychiatric medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Have others criticized your alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
Injuries or accidents?	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Have you faced DWI / DUI or drug charges?	<input type="checkbox"/>	<input type="checkbox"/>
Other health issues?	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____					

For each 'yes,' please give details: _____

Has any member of your family experienced mental illness or required psychiatric medications or hospitalization? Yes No If yes, please describe: _____

RELIGIOUS OR SPIRITUAL INFORMATION

Present religion or spiritual practice or tradition: _____

Childhood religion or spiritual practice or tradition: _____

Recent changes in your religious or spiritual life: _____

Meaningful religious or spiritual experiences, if any: _____

Form continues on the other side.

HOUSEHOLD & FAMILY INFORMATION

Name of spouse / partner: _____ Date of birth: _____ Age: _____

If married, date of marriage: _____ How long living together? _____ How long acquainted? _____

Previous marriages & relationships:

Name of previous spouse or partner	Date of marriage / living together	Date of separation / death	Date of divorce

Your children:

Name of your child	Sex	Age	Date of birth	Other parent	Lives with

Who else lives in your home? _____

INFORMATION ABOUT YOUR CHILDHOOD & FAMILY

Names of your parents / step-parents:	Divorced / moved out? (If yes, when?)	Still living? (If no, date of death?)	Helped raise you?
<i>Your mother:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Your father:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Step-parent:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Step-parent:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Other (describe):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

List brothers & sisters in birth order, INCLUDING YOURSELF

Names (Indicate if step-, half-, adopted or foster sibling.)	Sex	Age	City / state where currently residing	Marital history	Comments

How would you rate your childhood life? very happy happy average unhappy very unhappy

As a child, whom did you feel close to? mother father step-parent grandmother grandfather other _____

Comments on your childhood: _____

OTHER INFORMATION

Reasons for coming to therapy: _____

Please list significant events, concerns, or anything else that you may want us to know: _____