MAPS Counseling Services

Personal Information Form

☐ 19 Federal Street
Keene NH 03431
603-355-2244

☐ 9 Vose Farm Road
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 <u>current or past experience</u> with the following:

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

For each 'yes,' please give details: _____

Has any <u>member of your family</u> 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?
Your mother:	☐ Yes ☐ No	☐ Yes ☐No	☐ Yes ☐ No
Your father:		☐ Yes ☐ No	☐ Yes ☐ No
Step-parent:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Step-parent:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (describe):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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: _____