



# Maps Counseling Services

Navigating Life's Challenges

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## Personal Information Form

**INSTRUCTIONS:** This confidential, 2-sided form begins the dialogue with your therapist. Please fill in much information as you are comfortable completing.

### PERSONAL INFORMATION

Today's Date \_\_\_\_\_

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender / Sex: \_\_\_\_\_

Relationship 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 of 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/Providers: \_\_\_\_\_

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 ever 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: \_\_\_\_\_

*Form continues on the other side.*

**RELIGIOUS OR SPIRITUAL INFORMATION**

Do you follow particular religious or spiritual traditions? (Please specify) \_\_\_\_\_

What were your childhood religious or spiritual practices? \_\_\_\_\_

How important is spirituality in your life? \_\_\_\_\_

**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 & significant 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 / separated? (If yes, when?)	Still living? (If no, date of death?)	Helped raise you?
Your mother:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your father:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Step-parent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Step-parent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (describe):	<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 / relationship 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: \_\_\_\_\_

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

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