Maps Counseling Services

Navigating Life's Challenges

Personal Information Form

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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?	☐	☐	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 ever faced DWI / DUI or drug charges?	☐	☐
Other health issues?	☐	☐	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

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? ____________

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 & 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:	☐ 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 / 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: ____________________

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