Milwaukee Area Psychological Services, S.C. (MAPS)
401 E. Kilbourn Avenue, Suite 402
Milwaukee, WI 52302
414-269-8660 (phone) 414-269-8656 (fax)

New Client Information

Your responses to the following questions will help your psychologist better understand you and your situation. This will facilitate the best possible treatment. Please answer all questions as completely as possible.

Name: _____ Email address:_____

Address: _____ City/State/Zip: _____

Date of Birth: _____ SS#:_____

Occupation: _____ Employer: _____

Work phone number: _____ Home phone number: _____

Cell phone number: _____ Preferred phone number: ___work ___cell ___home

It is okay for my MAPS therapist to leave a message/voicemail at my preferred phone number (circle one)
Yes No

I have contact/communication concerns (circle one) Yes No
If yes, please specify: _____

Emergency contact: _____ Emergency contact phone: _____

Referred to MAPS by _____

Please fill in the blanks listed below, or check the "prefer not to answer" box.

Gender: _____ or ☐ prefer not to answer

Sexual orientation: _____ or ☐ prefer not to answer

Race: _____ or ☐ prefer not to answer

Ethnicity: _____ or ☐ prefer not to answer

Religious or Spiritual Orientation: _____ or ☐ prefer not to answer

Other aspects of your identity which are important to you (please list):

_____

_____

PRESENTING PROBLEM

Check here if you are experiencing any of the following problems:

___ Pain	___ Drug Abuse	___ Eating/Appetite	___ Marital/Relationship
___ Depression	___ Alcohol Abuse	___ Ill Health	___ Family
___ Unstable Mood	___ Stress Management	___ Sexual	___ Employment
___ Suicidal Thoughts	___ Anxiety/Worry	___ Financial	___ Body image

___ Other _____

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe the issue that brings you to therapy? _____

_____

When did the problem(s) begin? _____

How has it changed over time? _____

_____

PSYCHOLOGICAL HISTORY

Have you ever taken medication for anxiety for anxiety, depression, sleep, or other emotional conditions: ____Y _____N

If YES, what and when: _____

_____

Have you ever been in counseling or psychotherapy before? _____Y _____N

If YES, when, and where: _____

_____

Have you had any past hospitalizations for emotional problems? _____Y _____N

If YES, when, and where: _____

_____

Have you ever intentionally hurt yourself or made a suicide attempt? _____Y _____N

If YES, please explain how and when: _____

_____

MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced the following medical issues:

__Chronic Pain	__ Anemia	__ Allergies
__Heart (trouble, disease, surgery)	__ Thyroid problem	__ Sinus problems
__Chest pain or angina pectoris	__ Kidney or bladder problems	__ Weight change
__Abnormal blood pressure	__ Liver Disease	__ Eating problems
__ Fainting Spells	__ Hepatitis- type A B C	__ Ulcers/Abdominal pain
__ Epilepsy (Seizure Disorder)	__ Jaundice/rashes/sores	__ Venereal disease
__ Neurological disorders	__ Frequent or severe headaches	__ HIV positive/AIDS/ARC
__ Memory Loss	__ Hemophilia blood disease	__ Broken Bones
__ Stroke	__ Cancer/Tumors	__ Hearing problems
__ Arthritis/Rheumatism	__ Emphysema	__ Vision problems
__ Head Injury	__ Pregnancies not carried to term	__ Other _____

If you checked any of the above medical items, please explain: _____

Do you have any allergies or reactions to medications? ___Y ___N

If YES, what medications: _____

Are you taking any prescribed medications? ___Y___N

Who is your primary care physician? _____

Name of Medication	Dose and Frequency	Reason for Medication	Physician

Please indicate any homeopathic or alternative forms of medicine you are currently using: _____

_____

FAMILY HISTORY

Please list Parents, Siblings, Spouse/Partner, Children and Significant Relatives/Others:

Name (First, Last)	Relationship	Age	School/Occupation	City of Residence

Who raised you?

___Two Parents ___Mother alone ___Mother w/ partner ___ Father alone __Father w/ partner ___Other

Current Relationship Status:

___Single ___Long-term relationship ___Married ___Re-Married ___Divorced ___Separated ___Widowed

Who currently lives in your household? _____

_____

Are you having problems with your children? ___Y ___N ___No children

If YES, please explain: _____

_____

Have you ever experienced any emotional, verbal, physical, or sexual abuse? ____Y ____N

If YES, please explain: _____

_____

Are you concerned about alcohol or drug use of you or someone in your family? ____Y ____N

If YES, please explain: _____

_____

Did you grow up in a home in which a parent abused alcohol or drugs? ____Y ____N

If YES, please explain: _____

_____

How would you describe your parents' marital relationship? _____

_____

SOCIAL HISTORY

How do you relate to others? Check all that apply:

___ I seem to focus heavily on my interests
___ I am bothered by sounds, textures, smells that other people are not
___ Have many close friends
___ Have several close friends
___ Have few close friends
___ Have no close friends
___ Make friends easily
___ Am a leader
___ Am a follower
___ Fight with others
___ Prefer to be alone
___ Interact well with family members
___ Difficulty with siblings
___ Prefers younger friends
___ Am teased by others
___ Feel rejected by peer group
___ Have friends who get in trouble
___ Want friends, but don't know how to make or keep them
___ I have difficulty understanding jokes
___ I have difficulty understanding people's feelings
___ I stick to the same routine every day
___ I find change very stressful

If you've had trouble getting along with others, how long has this gone on? _____

_____

EDUCATIONAL AND VOCATIONAL HISTORY

Highest grade completed? ___ GED completed? __Y __N How did you do academically in school? _____

How was your conduct throughout school? _____

If attended college, what is your degree and /or status? _____

Are you currently employed? ___ Y ___ N

Have you ever been terminated from a job? ___Y ___N

If YES, please explain: _____

_____

Do you have any language or reading difficulties? ___Y ___N

If YES, please explain: _____

_____

MILITARY HISTORY

Did you ever serve in the military? ___Y ___N Branch of military? _____

Date/Type of Discharge: _____ Do you have combat history? ____Y ____ N

LEGAL HISTORY

Do you have a legal history consisting of past or current: (If YES to any of these, please explain)

Lawsuits ___ Y ___ N _____

Restraining Order ___ Y ___ N _____

Divorce/Custody ___ Y ___ N _____

Arrests ___ Y ___ N _____

Incarceration ___ Y ___ N _____

Probation ___ Y ___ N _____

GOALS

What goals would you like to accomplish in treatment?

1) _____

_____

2) _____

_____

3) _____

_____

Patient Signature: _____ Date: _____

Psychologist Signature: _____ Date: _____

ADULT SYMPTOM CHECKLIST

Please read each symptom or behavior listed and indicate how often you have experienced it (frequency) by circling the appropriate number, and how long you have experienced it (duration).

Symptoms	Rarely	3-4 times month	3-6 times week	Daily	How Long
1. Anxious, tense mood, difficulty controlling worry	0	1	2	3	
2. Panic attacks (intense and sudden fear)	0	1	2	3	
3. Anxiety and/or avoidance in social situations	0	1	2	3	
4. Specific intense fears (e.g. driving, needles, etc.) *Specify:*	0	1	2	3	
5. Obsessions and/or compulsions (excessive concern with cleanliness, orderliness, checking things, etc.).	0	1	2	3	
6. Having urges to break or smash things	0	1	2	3	
7. Difficulty concentrating and focusing on tasks	0	1	2	3	
8. Fatigue, feeling tired even with good sleep	0	1	2	3	
9. Feeling worthless, low self-esteem	0	1	2	3	
10. Decreased interest in previously enjoyed activities	0	1	2	3	
11. Feeling hopeless, things will never change	0	1	2	3	
12. Thoughts of suicide or death	0	1	2	3	
13. Seriously contemplating/planning suicide	0	1	2	3	
14. Sleep problems-too much or too little	0	1	2	3	
15. Decreased interest in sex	0	1	2	3	
16. Preoccupation with sexual thoughts/activities	0	1	2	3	
17. Appetite or weight markedly up or down	0	1	2	3	
18. Episodes of binge eating (with or without vomiting)	0	1	2	3	
19. Excessive worry about weight/body image	0	1	2	3	
20. Irritable mood, snapping at others, easily angered	0	1	2	3	
21. Episodes of rage, really “losing” it	0	1	2	3	
22. Unexplained “up” mood, restless, lots of energy	0	1	2	3	
23. Impulsive behavior that you wouldn’t “normally” do	0	1	2	3	
24. Racing thoughts that you cannot control	0	1	2	3	
25. Seeing/hearing things others tell you are not real	0	1	2	3	
26. Feeling nothing or “numb” emotionally	0	1	2	3	
27. Recurrent, intrusive thoughts or images	0	1	2	3	
28. Easily startled, overly “watchful”	0	1	2	3	
29. Feeling you are watched or talked about by others	0	1	2	3	
30. Difficulty trusting others and feeling safe	0	1	2	3	
31. Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	
32. Occupational concerns: job dissatisfaction, problems with employer or co-workers	0	1	2	3	
33. Parenting concerns, difficulty managing children	0	1	2	3	
34. Relationship problems with spouse or other(s)	0	1	2	3	
35. Use of caffeine (coffee, cola, tea, Mt. Dew, etc.)	0	1	2	3	

36. Smoking cigarettes	**0**	**1**	**2**	**3**	
37. Drinking alcohol (beer, wine, liquor)	**0**	**1**	**2**	**3**	
38. Use of prescription drugs in non-prescribed ways	**0**	**1**	**2**	**3**	
39. Use of marijuana, cocaine, or other street drugs	**0**	**1**	**2**	**3**	