

Milwaukee Area Psychological Services, S.C. (MAPS)
759 N. Milwaukee St., Suite 414
Milwaukee, WI 53202

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: _____ Legal Name (if using insurance): _____

Pronouns: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Preferred phone: ___ work ___ cell ___ home Phone Number: _____

Email Address: _____

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: _____

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:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating/Appetite | <input type="checkbox"/> Marital/Relationship |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Ill Health | <input type="checkbox"/> Family |
| <input type="checkbox"/> Unstable Mood | <input type="checkbox"/> Stress Management | <input type="checkbox"/> Sexual | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Financial | <input type="checkbox"/> Body image |
| <input type="checkbox"/> 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:

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

If you checked any of the above medical items, how do they impact the concerns that are bringing you to therapy: _____

Are you taking any prescribed medications? ___Y___N

Who is your primary care physician? _____

Name of Medication	Dose and Frequency	Reason for Medication

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

Your current relationship status: _____

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: _____

Who raised you?

___ Two Parents ___ Mother alone ___ Mother w/ partner ___ Father alone ___ Father w/ partner ___ Other: _____

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' relationship? _____

SOCIAL HISTORY

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

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

Occupation: _____

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) _____

Referred to MAPS by/How did you find us? _____

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.) <i>Specify:</i>	0	1	2	3	
5. Obsessions and/or compulsions	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 but doctors finding nothing wrong	0	1	2	3	
32. 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	