The Personal Wellness Center

6508 Deer Pointe Dr. Ste. 4C, Salisbury, Maryland 21804
Telephone: 410-742-6016

PERSONAL INFORMATION

Upon arrival please submit insurance card and driver's license (to be copied), referrals and any other applicable paperwork. Thank you

Today's date: _____

Name: _____ **Middle** _____ **Last**: _____

Birthdate: _____ **Age**: _____

What sex was assigned at birth? (Check one)

◉ Male ○ Female ○ Other ○ Decline to answer

What is your current gender identity? (Check ALL that apply)

○ Male ○ Female ○ Transgender Male/Transman/FTM ○ Transgender Female/Transwoman/MTF
○ Gender Queer ○ Additional category (please specify): _____
○ Decline to answer

Do you identify as: (check all that apply)

○ Straight ○ Gay ○ Lesbian ○ Bisexual ○ Other: _____ ○ Decline to answer

Home address: _____

City _____**State**_____ **Zip Code**_____

E-mail address: _____

Phone Number: _____ _____ _____

Home Cell Work

****If you prefer not to be included in our monthly newsletter, please let us know****

Relationship status: ☐ single ☐ married ☐ In a civil union ☐ In a domestic partnership, living together ☐ Partnered, not living together ☐ Divorced ☐ Widowed ☐ In a committed relationship ☐ Other:_____

Number of dependent children under the age of 18 _____

Are you a veteran? ○ Yes ○ No

Person to contact in case of emergency: _____

Phone #: _____ **Relationship** _____

Name, address, phone # for person responsible for payment: _____

Referred to The Personal Wellness Center by _____

Name of primary care physician _____

Have you ever had counseling or therapy prior to today?

Previous diagnosis: _____

History of mental health illness in the family?

Known diagnoses: _____

Your health

Current health concerns: _____

_____

Developmental concerns: _____

_____

Current prescribed medications: _____

_____

History of head injury: _____

Allergies: _____

Education

Highest level of education? Choose one ____

Have you ever been diagnosed with ADHD or a learning disability? Choose one..

Have you ever received special education services? Choose one..

Have you ever been held back in school? Choose one..

Have you ever been evaluated? Choose one..

Have you ever been suspended or expelled from school? Choose one..

Drug and alcohol history

Do you currently use alcohol or recreational drugs? Choose one...

If yes, how frequent do you use? Choose one... per week. Please enter date of last time you used _____

In the past, have you used alcohol or recreational drugs? Choose one..

Have you received treatment for alcohol or drugs? Choose one..

Has anyone in your family had a problem with drugs or alcohol? Choose one..

Safety Concerns

Have you ever had thoughts of harming or killing yourself? Choose one.. When: _____

Have you ever attempted to commit suicide? Choose one.. How: _____

Have you ever had thoughts of hurting others? Choose one.. When: _____

Have you ever attempted to hurt someone else? Choose one.. How: _____

Legal Concerns

Have you ever been arrested? Choose one.. When: _____

Current or past legal problems? Choose one.. Explain: _____

Are you currently on probation? Choose one.. Until:_____

Primary language: ☐ English ☐ Spanish ☐ Other Specify _____

Living situation: ◯Private Home ◯Foster Home ◯Residential Care ◯Institutional Setting ◯Homeless ◯Other

Specify:_____

Disability Status: ☐Hearing problems ☐Vision Problems ☐Difficulty Walking ☐ Difficulty Dressing/Bathing

☐Difficulty doing errands alone ☐Other Specify _____

Spanish/Latino origin Choose one..

Race: ☐White ☐ African American ☐American Indian or Alaskan Native ☐ Asian ☐Native Hawaiian or Other Pacific Islander ☐ Multi-Racial

Please describe your sexual activity during the last year (check all that apply):

☐I was in a monogamous relationship with a man. (I had sex with one man only)

☐I was in a monogamous relationship with a woman. (I had sex with only one woman)

☐I had multiple male partners ☐I had multiple female partners. ☐I had both male and female partners.

☐I did not have any sexual partners. ☐Other: _____ ☐Decline to answer

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

Primary Insurance Information

Insurance carrier: _____ Policy # _____

Insured's Name: _____

Person who is primary on insurance:

Insured's Address: _____

Insured's Birthdate _____Insured's Employer _____

Secondary Insurance Information -if applicable

Insurance carrier: _____ Policy # _____

Insured's Name: _____

Person who is primary on insurance:

Insured's Address: _____

Insured's Birthdate _____Insured's Employer _____

What specific goals would you like to work on in therapy?

1. _____
2. _____
3. _____