CRYSTAL COUNSELING
Growth and Clarity

116 Gallery Circle #201
San Antonio, TX 78258
Phone: 210-802-4695

Adult Personal History

Client's Name: _____ Date:_____

Gender: ___F ___M Date of Birth: ___/___/_____ Age: _____

Phone (home): _____ (work): _____ (cell): _____

Okay to leave messages □Voice □ Text On what number may we leave a confidential message: □Home □Cell □Work
Email Address_____

Emergency Contact Person: _____ Phone: _____

Relationship to client: _____

Counseling I am seeking: ____Individual Therapy ____Couple Therapy ____ Group Therapy

Primary reason(s) for seeking service.

____ Anger management	____ Anxiety	____ Self-Harming Behaviors	____Depression
____ Eating disorder	____ Parenting	____ Stress	____ Fear/phobias
____ Sleeping Disturbance	____ Suicidal Ideations	____Depression/Sadness	____ Hyperactivity
____ Self-Esteem	____ Alcohol/Drugs	____ Inattentiveness	____ Gender Identity
____ Marital Conflict	____ Infidelity	____ Grief	____ Chronic Pain
____ Abuse (Physcial, Mental, Sexual)			

_____
_____
_____

PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number):

1	2	3	4	5	6
Not intense			Moderately Intense		Extremely Intense

When did you first notice onset of the reason you are seeking services:
_____

How long has this been a problem/concern:
_____

Have you **seen another therapist** in the past twelve months? ___Yes ___No
If yes, who did you see and how long? _____

Have you been hospitalized for any Mental Illness? Yes No How many times? _____
When? _____
Describe how the onset of the reason you are seeking assistance is negatively impacting your life:
_____
_____
_____

Have you had **suicidal thoughts** recently? ___frequently ___sometimes ___rarely ___never
Have you had them in the past? ___frequently ___sometimes ___rarely ___never

Have you ever intentionally inflicted any harm upon yourself? ___Yes ___No ___Unsure

CRYSTAL COUNSELING
Growth and Clarity

116 Gallery Circle #201
San Antonio, TX 78258
Phone: 210-802-4695

Client Medical / Physical Health

___Abortion ___Asthma ___Blackouts ___ Diabetes ___Dizziness ___ Heart Trouble
___Hives ___ Meningitis ___Miscarriage ___ Pregnancy ___ Seizures ___ Hepatitis
___ Severe head injury ___Thyroid disorder ___ Sexually transmitted disease ___Other _____
List any current health concerns:

_____
_____
_____

When was your last medical appointment with your doctor? _____
Did you discuss your current symptoms: ___Yes ___ No
What were the results of the appointment?

_____
_____

Please check if there have been any recent changes in the following:

___ Sleep patterns ___Eating patterns ___Physical activity level ___Energy level ___Attention level
___ Behavior ___Weight ___ General disposition ___Nervousness
Describe the changes in areas checked above:

_____
_____
_____

Medications (Please list all medications)

Currently prescribed medications	Dose	Frequency	Date Started	Purpose	Side Effects
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes

List any medication allergies:

_____

Chemical Use History

Does the client use or have a problem with alcohol or drugs? ___No ___Yes
If Yes, please describe alcohol and/or drugs used:

_____
_____
_____
_____

Family History (Please check any past, present, or impending **special problems in your family**)

___deaths ___divorce ___frequent relocations
___serious illness ___debilitating injuries/disabilities ___alcohol/drug abuse
___psychiatric disorder ___physical/sexual abuse ___legal problem
___financial crisis/unemployment ___attempted/completed suicide ___eating disorders
___other _____

Please specify **family member(s), with special problems**, and approximate year of occurrence (e.g. mother, serious illness,1998, etc.)

_____
_____

CRYSTAL COUNSELING
Growth and Clarity

116 Gallery Circle #201
San Antonio, TX 78258
Phone: 210-802-4695

_____

_____

Partner Status

Date Married or Plan to be Married (if applicable): _____
Have you been married before, and if so, how many times? _____
How long have you and your partner been in this relationship? _____
Are you and your partner presently living together? Yes _____ No _____
Are you and your partner engaged, separated, or in any litigation or arbitration (please explain)?
_____

What would you like to accomplish out of your time in couples therapy?:
_____ _____
_____
_____

Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in?_____
Are you in one now? ___Yes ___No ___I think so

Besides family members, approximately how many people can you really count on right now for friendship or **emotional support**? _____

Cultural Background: What is your **ethic identity**?

___African/African American ___Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
___East Indian/Pakistani ___Latino/ Hispanic/ Mexican-American/ Puerto Rican
___Middle Eastern ___Native American/ Alaskan Native
___Polynesian/Micronesian ___White/Caucasian
___Other (specify) _____
How much do you identify with your **ethnic heritage**? (Check one):

___Not at all ___A little ___Somewhat ___Moderately ___Strongly

Religious/Spiritual Background:

Do you consider yourself a religious person?___Yes ___No or spiritual person? ___Yes ___No
Explain: _____
Faith: Group/Denomination in which you were raised: _____
Current Congregation/Church: _____
How active are you? _____Inactive ____ Slightly _____ Moderate ____Very

Academic Background:

Where did you attend high school?
_____

Did you attend college/professional school? When, where, degree earned?
_____

Any plans to further your education? _____ If so, when and what?
_____

_____

CRYSTAL COUNSELING
Growth and Clarity

116 Gallery Circle #201
San Antonio, TX 78258
Phone: 210-802-4695

Please list any additional **information that you believe will be helpful** for your therapist to know.

_____
_____
_____
_____

For Staff Use

Therapist's comments:

_____
_____
_____
_____
_____
_____
_____

Therapist's signature/credentials: _____ Date: _____

Supervisor's signature/credentials: _____ Date: _____