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 ____ Family 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:
_____

List any current mental/behavioral health diagnosis_____
_____
_____

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? _____ Diagnosis_____

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Describe how the issue 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

Client Medical / Physical Health

□ Allergies
□ Anemia
□ Asthma
□ Bleeding tendency
□ Blindness
□ Cancer
□ Cerebral Palsy
□ Cleft lips/Palate
□ Deafness
□ Other
□ Diabetes
□ Glandular problems
□ Heart disease
□ High blood pressure
□ Kidney disease
□ Learning disabilities
□ Mental illness
□ Migraines
□ Multiple sclerosis
□ Muscular Dystrophy
□ Nervousness
□ Perceptual motor disorder
□ Mental retardation
□ Seizures
□ Sexual abuse
□ Substance abuse
□ Suicide
□ HIV/AIDS

List any other 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:

_____

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Chemical Use History

Does the client use or have a problem with alcohol or drugs? ___No ___Yes

If yes please check all that apply.

□ Alcohol
□ Barbiturates
□ Benzodiazepines
□ Cocaine
□ Crack Cocaine
□ Crystal Meth
□ Ecstasy
□ Heroin
□ Inhalants
□ LSD
□ Marijuana
□ Nicotine/Tobacco
□ PCP
□ Prescription Opioids
□ Street Methadone
□ Other

Please list other

_____

_____

_____

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

□ Allergies
□ Anemia
□ Asthma
□ Alcohol Abuse
□ ADHD
□ Anxiety
□ Bleeding Tendency
□ Blindness
□ Cancer
□ Cerebral Palsy
□ Cleft Llips/Palate
□ Chronic Fatigue
□ Depression
□ Deafness
□ Death
□ Divorce
□ Debilitating injuries/TBI
□ Eating Disorder
□ Financial Crisis/Unemployment
□ Frequent Relocation
□ Glandular Problems
□ HIV/AIDS
□ Heart Disease
□ High Blood Pressure
□ Infidelity
□ Kidney Disease
□ Learning Disabilities
□ Legal Problems
□ Mental illness
□ Migraines
□ Multiple sclerosis
□ Muscular Dystrophy
□ Nervousness
□ Physical Abuse
□ Perceptual Motor Disorder
□ PMS
□ Mental/Emotional Abuse
□ Mental retardation
□ Seizures
□ Sexual abuse
□ Sleep Disturbance/Disorder
□ Sexual Dysfunction
□ Substance abuse
□ Suicide/Attempted suicide
□ Other

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

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

_____

_____

_____

_____

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? _____

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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)?
_____

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**?

___Black/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:

Highest Level of Education: (Check One)

____High School ____Associates ____Bachelor ____Masters ____PHD ____Some College ____Technical

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

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: _____

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