Crystal Counseling
116 Gallery Circle #201
San Antonio, TX 78285
Phone 210-802-4695

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: _____

What are your primary concerns about the relationship?

_____

_____

_____

Relationship Status: (check all that apply)

☐ Married ☐ Living Together ☐ Divorced ☐ Separated ☐ Living apart ☐ Dating

How long have you and your partner been together?_____

Please list previous marriages/significant relationships (Partner's Name, # of children from Marriage/Relationship, Length of Relationship, Reason for Ending Relationship)

_____

_____

_____

Please list all children: Please add Name, M/F, Age, where living.

_____

_____

_____

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

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What initially attracted you to your partner?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

_____

How comfortable are you if your partner spends free time away from you?

_____

_____

_____

Do you have relationships with other people that create conflict with yourpartner, and if so, why?

_____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship. (1 = extremely unhappy ; 10= extremely happy)

1 2 3 4 5 6 7 8 9 10

(Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

_____

_____

Have you received prior couples counseling related to any of the above problems? ☐ Yes ☐ No

If yes, With whom:_____

Where: _____ Length of treatment_____

Outcome: _____

Have either you been in individual counseling before? ☐ Yes ☐ No

If so, give a brief summary of concerns you addressed.

_____

_____

_____

Check all mental/behavioral concerns/issues.

____ 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

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____ Marital Conflict ____ Infidelity ____ Grief ____ Chronic Pain
____ Abuse (Physcial, Mental, Sexual)
Other_____
_____
_____

Have you been hospitalized for any Mental Illness? Yes No How many times? _____
When? _____
Is this 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
___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

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List any medication allergies:

_____

Do either you or your partner drink alcohol or take drugs to intoxication? ☐ Yes ☐ No

If yes , for either, who, how often and what drugs or alcohol?

_____

_____

_____

Do you ever wish your partner would cut back on his/her drinking or drug use? ☐ Yes ☐ No ☐ N/A

Have either you or your partner struck, physically restrained, used violence against or injured the other person? ☐Yes ☐No If yes, who, how often and what happened?

_____

_____

_____

Are there any pending legal issues? Child custody? Restraining orders?

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems? ☐ Yes ☐ No If yes, who? ☐Me ☐ Partner ☐ Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

What is your current level of stress (overall)? (Circle one)(1 = no stress; 10 = high stress)

1 2 3 4 5 6 7 8 9 10

What is your current level of stress (in the relationship) (1 = no stress; 10 = high stress)

1 2 3 4 5 6 7 8 9 10

How aware or in touch with your emotions are you (1 = not at all; 10 = extremely)

1 2 3 4 5 6 7 8 9 10

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How open are you in expressing your innermost feelings, desires and thoughts to your partner (1 = not at all; 10 = extremely)

1 2 3 4 5 6 7 8 9 10

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.)

_____

_____

_____

_____

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?

_____

_____

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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: _____

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Name_____ Date_____

Couple Satisfaction Checklist

Place a check (√) in the box to the right of each relationship category that best describes how satisfied you feel today about your relationship.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check (√) 3 areas you want most to change
1. Degree of closeness, confiding, sharing and comforting.							
2. Expression of affection and caring.							
3. Satisfaction with sexual intimacy.							
4. Handling conflicts and arguments.							
5. Expression of anger, criticism or blame.							
6. Handling family finances.							
7. Handling of parenting issues							
8. Handling of Household Tasks							
9. Common interests and social life							
10. Degree of respect and admiration for Your partner							
11. Satisfaction with your role in the relationship							
12. Satisfaction with your partner's role in the relationship							

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13. Overall satisfaction with Your relationship							