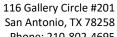


CRYSTAL COUNSELING Growth and Clarity

Adult Personal History

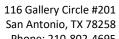
Client's Name:		Date:			
Gender:FM	Date of Birth:/	Age:			
Phone (home):	(work):	(cell):			
□Work	pice □ Text On what numbe	r may we leave a confidential me	essage: Home Cell		
Emergency Contact Person:		Phone:			
Relationship to client:					
Counseling I am seeking: Primary reason(s) for seeki Anger management Eating disorder Sleeping Disturbance Self-Esteem Marital Conflict Abuse (Physcial, Meni	ng service. Anxiety Parenting Suicidal Ideations Alcohol/Drugs Infidelity	Couple Therapy Group The Self-Harming Behaviors Stress Depression/Sadness Inattentiveness Grief			
PROBLEM INTENSITY: How wou	ld you rate the intensity of the prob	olem or concern that brought you in? (Cir	cle the appropriate number):		
1 2 Not intense		4 5 lerately Intense	6 Extremely Intense		
When did you first notice or	nset of the reason you are see	eking services:			
How long has this been a pr	oblem/concern:				
List any current mental/beh	avioral health diagnosis				
Have you seen another therapist If yes, who did you see and how lo		YesNo			
Have you been hospitalized When?	for any Mental Illness? Yes	No How many times? Diagnosis			





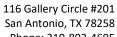
San Antonio, TX 78258 Phone: 210-802-4695

Describe how the issue is negatively impacting your life:						
Have you had suicidal thoughts recently? Have you had them in the past?	frequently	sometime		never		
Have you ever intentionally inflicted any har	m upon yourself'	?Yes	No	Unsure		
Client Medical / Physical Health						
□ Allergies	□ Diabetes		□ Muscul	ar Dystrophy		
□ Anemia	□ Glandular	problems	□ Nervou			
□ Asthma	□ Heart dise	-	□ Percept	ual motor disor	der	
☐ Bleeding tendency	☐ High blood		•	retardation		
□ Blindness	☐ Kidney dis		□ Seizure			
□ Cancer	□ Learning d			□ Sexual abuse		
□ Cerebral Palsy	□ Mental illr			□ Substance abuse		
□ Cleft lips/Palate	□ Migraines		□ Suicide			
□ Deafness	□ Multiple s		□ HIV/AI)S		
□ Other			,			
List any other current health conce	rns:					
When was your last medical appoir Did you discuss your current symp What were the results of the appoir	toms:Yes					
Please check if there have been and Sleep patterns Eating patt Behavior Weight Describe the changes in areas chec	ernsPhy Ge	ges in the follow vsical activity lev neral disposition	elEnergy l		ntion level	
Medications (Please list all medica Currently prescribed medications	tions) 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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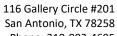
Chemical Use History					
Does the client use or have a proble	em with alcohol or drugs?No	_Yes			
If yes please check all that apply.					
□ Alcohol	□ Inhalants				
□ Barbiturates	□ LSD				
□ Benzodiazepines	□ Marijuana				
□ Cocaine	□ Nicotine/Tobacco				
☐ Crack Cocaine	□ PCP				
☐ Crystal Meth	□ Prescription Opioids				
□ Ecstasy	□ Street Methadone				
□ Heroin	□ Other				
Please list other					
Family History (Please check any past,	present or impending special problems in	vour family)			
□ Allergies	Divorce	□ Multiple sclerosis			
□ Anemia	☐ Debilitating injuries/TBI	□ Muscular Dystrophy			
□ Asthma	□ Eating Disorder	□ Nervousness			
□ Alcohol Abuse	☐ Financial Crisis/Unemployment				
□ ADHD					
□ Anxiety	□ Glandular Problems	□ Perceptual Motor Disorder			
☐ Bleeding Tendency					
- · · · · · · · · · · · · · · · · · · ·	·	□ Mental/Emotional Abuse			
□ Blindness	☐ Heart Disease	□ Mental retardation			
□ Cancer	☐ High Blood Pressure	□ Seizures			
□ Cerebral Palsy	□ Infidelity	□ Sexual abuse			
□ Cleft Llips/Palate	☐ Kidney Disease	□ Sleep Disturbance/Disorder			
□ Chronic Fatigue	☐ Learning Disabilities	☐ Sexual Dysfunction			
□ Depression	□ Legal Problems	☐ Substance abuse			
□ Deafness	□ Mental illness	☐ Suicide/Attempted suicide			
□ Death	□ Migraines	□ Other			
deathsserious illnesspsychiatric disorderfinancial crisis/unemployment other	divorcedebilitating injuries/disabilitiesphysical/sexual abuseattempted/completed suicide	frequent relocations alcohol/drug abuselegal problemeating disorders			
	ecial problems, and approximate year of oc	currence (e.g. mother, serious illness,1998, etc.)			
Partner Status					
Date Married or Plan to be Married Have you been married before, and					
How long have you and your partner					





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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?
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 AmericanAsian American/ Chinese/ Filipino/ Japanese/ Korean/ VietnameseEast Indian/PakistaniLatino/ Hispanic/ Mexican-American/ Puerto RicanNative American/ Alaskan NativePolynesian/MicronesianWhite/CaucasianOther (specify) How much do you identify with your ethnic heritage? (Check one):
Not at allA littleSomewhatModeratelyStrongly
Religious/Spiritual Background:
Do you consider yourself a religious person?YesNo or spiritual person?YesNo Explain: Faith: Group/Denomination in which you were raised: Current Congregation/Church: How active are you?Inactive Slightly ModerateVery
Academic Background:
Highest Level of Education: (Check One)
High SchoolAssociatesBachelorMastersPHDSome CollegeTechnical
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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