

Texas Military Department Counseling Program

**SELF-REPORT BIOPSYCHOSOCIAL - COUPLES COUNSELING**

**Prior to completing this form, please review the Informed Consent for Treatment**

Both partners need to complete this form *separately/independently*. Please return prior or bring to your first session.

**Demographic Information**

Name: DOD ID#:

Home#: Mobile#: Work#:

Address: Street Address City County State Zipcode

Sex (In Deers): Female Male DOB:

What is your preferred method of contact? Email Phone

May we leave voicemails? Yes No If yes: Home Work Mobile

Rank: Component: TXARNG TXANG TXSG Family Member

Brigade/Wing: Years of Service: Duty Status: M-Day AGR ADOS

If on current State Active Duty orders, please list mission:

Do you believe your current issues are military service related? Yes No

Commanding Officer Name & Contact #:

Ethnicity: Black/African American White/Caucasian Hispanic/Latino Other

Primary Language: English Spanish Other:

Marital Status (in DEERS): Single Married Separated Divorced Widowed

Emergency Contact Name:

Emergency Contact #: Emergency Contact Address:

Employment: Full-Time Part-Time Looking for Employment Not Employed

Employer:

Insurance: Yes No If yes, insurance company:

Mental Health Benefits? Yes No

How were you referred to our program? BH Chaplain Commanding Officer

Community Resource FSS J9 SAPR Self Other



Current/pending or history of legal involvement or charges? Yes No  
Current Psychiatric Treatment? Yes No

If yes, please provide details (diagnosis, psychotropic medications currently prescribed/taking):

History of outpatient mental health treatment? Yes No

If yes, please provide details (timeframes, diagnosis, treatment, was it helpful or not, etc.):

History of inpatient behavioral health hospitalization? Yes No

If yes, please provide details (timeframes, diagnosis, treatment, was it helpful or not, etc.):

Family history of mental health related concerns or conditions?

How would you describe your physical health?

Current medical conditions/issues (include any diagnosis and whether treated/managed well):

Current medications and/or supplements prescribed/taking:

History of brain injury, including TBI? Yes No If yes, provide details:

Current alcohol and/or substance use? Yes No

History of alcohol and/or substance use? Yes No

If yes, provide details:

Family history of alcohol and/or substance misuse? Yes No

If yes, provide details:

## Relationship Information

Length of time with current spouse/partner:

As you think about the primary reason that brings you to couples counseling, how would you rate your overall level of concern at this point in time?      No concern      Somewhat      Moderate      Serious

What was the prompting event that led to you seeking couples counseling **now**?

Rank the top three concerns that you have in your relationship with your partner (#1 being the most problematic):

- 1.
- 2.
- 3.

How long have these concerns been occurring?

What have you already done to deal with these difficulties?

Has either you threatened to separate or divorce as a result of the relationship problems?      Yes      No

If yes, who?      Me      Partner      Both of Us

If married, have either of you consulted with a lawyer about divorce?      Yes      No

If yes, who?      Me      Partner      Both of Us

Have either of you taken physically forceful actions during disagreements?      Yes      No

If yes, who?      Me      Partner      Both of Us

...And, if yes, how often does or has this occurred?

Are physical actions/responses still occurring in the relationship?      Yes      No

Have you ever wished your partner would cut back on their alcohol or substance use?      Yes      No

Has your partner expressed the desire for you to cut back on your alcohol or substance use?      Yes      No

Have either of you threatened to harm self in response to an argument or break-up?      Yes      No

If yes, who?      Me      Partner      Both of Us

...And, if yes, how many times has this occurred?

Do you feel that either of you is withdrawn from the relationship?      Yes      No

To your knowledge, have either of you ever engaged in emotional or physical infidelity in this relationship?

Yes      No      If yes, who?      Me      Partner      Both

...And, if yes, is it still ongoing?      Yes      No

When disagreements arise, they usually involve...

becoming very angry/over-reactive:	Me	Partner	Both of Us
blaming for our problems:	Me	Partner	Both of Us
withdrawing affection:	Me	Partner	Both of Us
becoming critical:	Me	Partner	Both of Us
becoming unclear or unable to express self clearly in speech:	Me	Partner	Both of Us
giving in or apologizing:	Me	Partner	Both of Us
ignoring feelings and/or concerns:	Me	Partner	Both of Us
abruptly leaving the room or house without notice:	Me	Partner	Both of Us
other:			

Please rate your current level of relationship satisfaction:

(extremely dissatisfied) 0 1 2 3 4 5 (extremely satisfied)

To what degree does your family and/or friends support you as a couple?

(extremely unsupportive) 0 1 2 3 4 5 (extremely supportive)

To what degree do you feel support and encouragement from your partner?

(extremely unsupportive) 0 1 2 3 4 5 (extremely supportive)

To what degree do you feel trust in your partner?

(extremely untrusting) 0 1 2 3 4 5 (extremely trusting)

Rate how open you are in expressing your innermost wants, thoughts, and feelings to your partner:

(totally closed) 0 1 2 3 4 5 (totally open)

To what degree do the two of you share a similar basic worldview/set of values?

(extremely dissimilar) 0 1 2 3 4 5 (extremely similar)

How enjoyable is your sexual relationship?

(extremely unpleasant) 0 1 2 3 4 5 (extremely pleasant)

How satisfied are you with the frequency of your sexual activities?

(extremely dissatisfied) 0 1 2 3 4 5 (extremely satisfied)

How important do you value physical intimacy and sex in your relationship?

(extremely unimportant) 0 1 2 3 4 5 (extremely important)

What are your biggest **strengths** as a couple?

What qualities do you enjoy most about your partner?

What is at least one thing your partner does very well and would love for them to keep doing?

What is at least one thing you're willing to do to improve the relationship regardless of what your partner does?

How would you describe your roles in the relationship (include any cultural and tradition context or difficulties)?

Please describe any significant or stressful life events, outside of your relationship with your partner, that you have been experiencing and have not already mentioned above (include how stress manifests, if applicable):

Any other information you feel is relevant for your counselor to know at this time?

## General Anxiety Disorder (GAD-7)

NAME:

DATE:

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or Irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>				
<b>TOTAL SCORE</b> <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring** Add the results for question number one through seven to get a total score.

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

**A score of 10 or higher means significant anxiety is present. Score over 15 are severe.**

### GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

Name:

Date:

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

FOR OFFICE CODING 0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
=Total Score: \_\_\_\_\_

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SHORT  
FORM  
PCL-5**

Date: \_\_\_\_\_

Name \_\_\_\_\_

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping the worst event in mind, read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past WEEK.

<i>In the past week, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
2. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
3. Feeling distant or cut off from other people?	0	1	2	3	4
4. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
<b>COLUMN SUM</b>					

**TOTAL** \_\_\_\_\_

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD  
Zuromski et al (2019). Developing an optimal short-form of the PTSD Checklist for DSM-5 (PCL-5). *Depress Anxiety*, 36, 790-800.

Threshold 6+

Name:

Date:

## Perceived Stress Scale (PSS-10)

### Instructions:

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

In the last month, how often have you...

		Never	Almost Never	Sometimes	Fairly Often	Very Often
1	been upset because of something that happened unexpectedly?	0	1	2	3	4
2	felt that you were unable to control the important things in your life?	0	1	2	3	4
3	felt nervous and "stressed"?	0	1	2	3	4
4	felt confident about your ability to handle your personal problems?	4	3	2	1	0
5	felt that things were going your way?	4	3	2	1	0
6	found that you could not cope with all the things that you had to do?	0	1	2	3	4
7	been able to control irritations in your life?	4	3	2	1	0
8	felt that you were on top of things?	4	3	2	1	0
9	been angered because of things that were outside of your control?	0	1	2	3	4
10	felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

**TOTAL:**

### Developer Reference:

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan & S. Oskamp (Eds.), *The social psychology of health: Claremont Symposium on applied social psychology*. Newbury Park, CA: Sage.

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