Texas Military Department Counseling Program

SELF-REPORT BIOPSYCHOSOCIAL – FAMILY COUNSELING

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

All adult family members need to complete this form *separately/independently*. Please return prior or bring to your first session.

Demographic Information

Name: _____ Email: _____

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

Client Information and History

What information about your upbringing do you find relevant and important for us to know (please include any family, socioeconomic, academic, geographical, cultural, and spiritual, or other factors):

Highest Level of Education: Associates ☐ Bachelors ☐ Masters ☐ High School/GED
☐ Some College ☐ Trade/Technical School ☐ Other

Current Employment or Academic Stressors? ☐ Yes ☐ No

Financial Status: ☐ Stable ☐ Financial Stress

Areas of Financial Need (housing, utilities, childcare, transport, credit repay, etc.):

Current Living Situation: ☐ live alone ☐ live with family/friend(s)/roommate(s)
☐ homeless ☐ military housing ☐ inconsistent housing ☐ other

Name of partner/spouse:

Length of time with current partner/spouse:

Do you have any children? If yes, provide name(s), age(s), and specify if they reside with you:

Describe your current support system (types or names of supports, if applicable):

Military history (please include any active duty, MOS, deployment, and activation history you feel is relevant for us to know):

Current benefits and/or stressors related to military service?

Current military resources utilized: ☐ VA ☐ Peer Support Group ☐ LOD in place/pending
☐ Vet Center ☐ TX Substance Abuse Counselor ☐ MEB Pending ☐ Other

Current or history of military-related disciplinary action(s)? If yes, provide details (issues, date, disposition):

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

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 family counseling **now**?

Rank the top three concerns that you have in your relationship with your family members (#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 anyone in your family ever taken physically forceful actions during disagreements? ☐ Yes ☐ No

If yes, who? ☐ Me ☐ Other family member(s):

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

Have you ever wished a family member would cut back on their alcohol or substance use? ☐ Yes ☐ No

Has a family member expressed desire for you to cut back on your alcohol or substance use? ☐ Yes ☐ No

Have anyone in the family threatened to harm self in response to an argument or in general? ☐ Yes ☐ No

If yes, who and how often has this occurred:

Do you feel that anyone in your family has withdrawn or given up on trying to work things out?

☐ Yes ☐ No If yes, who?

When disagreements arise, they usually involve…

becoming very angry/over-reactive: ☐ Me ☐ Other family member(s)

blaming for our problems: ☐ Me ☐ Other family member(s)

withdrawing affection: ☐ Me ☐ Other family member(s)

becoming critical: ☐ Me ☐ Other family member(s)

becoming disorganized in communication: ☐ Me ☐ Other family member(s)

giving in or apologizing: ☐ Me ☐ Other family member(s)

ignoring feelings and/or concerns: ☐ Me ☐ Other family member(s)

abruptly leaving the room or house without notice: ☐ Me ☐ Other family member(s)

other conflict behaviors:

Please rate your current level of family relationship satisfaction:

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

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

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

To what degree do you feel trust in your family?

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

Rate how open you are in expressing your innermost wants, thoughts, and feelings with your family:

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

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

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

What is your current level of family stress (overall)?

(no distress) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 (most distress)

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

What qualities do you enjoy and like most about your family?

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

What are the family/household rules:

Please describe any significant or stressful life events, outside of your relationship with your family, 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	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column	0	0	0	0
TOTAL SCORE *(add your column scores)*	0			
	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?	☐	☐	☐	☐

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

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Reset Form

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 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
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 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING 0 + 0 + 0 + 0

=Total Score: 0

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**
☐	☐	☐	☐

Reset Form

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
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** ○
COLUMN SUM					

TOTAL 0

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+

Clear Form

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: 0

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.

Clear Form