For counselor use only

Intake Date:	
Counselor:	
Fee:	Previous client: yes or no
Dates of previous counseling:	

RESTORE HOPE COUNSELING AT FBC EASTLAND INFORMATION FORM

Welcome to Restore Hope Counseling. In order to serve you better, we request that you take a few moments to fill out the following information.

Full Name _____

Address _____

City _____ State _____ Zip _____

Home/Cell Phone _____Work Phone _____

Email _____

Date of Birth _____ Age _____ Male _____ Female _____

Occupation_____

May we call you at your home? _____Yes _____ No

May we call you at your office? _____Yes _____No

May we email/write you at your home? _____Yes _____No

May we leave a message at your home? _____ Office? _____

Current Marital Status:

_____ Never Married ____ Married ____Divorced ____Separated ____ Widowed

Name of Spouse (if applicable) _____

Date of Marriage _____

PREVIOUS MARITAL HISTORY:

Self:

Name of Previous Spouse Date of Marriage Date of Divorce/Death

_____ _____ _____

_____ _____ _____

Spouse:

Name of Previous Spouse Date of Marriage Date of Divorce/Death

_____ _____ _____

_____ _____ _____

_____ _____ _____

Your Education Level: _____ GED _____ High School Diploma

_____ College Degree _____ Graduate Degree Degree In _____

Spouse's Education Level: _____ GED _____ High School Diploma

_____ College Degree _____ Graduate Degree Degree In _____

Children:

Name Gender Age Father's/Mother's First Name

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PERSONAL INFORMATION:

Your Employer:_____ Position:_____

Are you currently attending a church? _____ Yes _____No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Are you a born-again Christian? ____ Yes ____No ____Unsure

Are religious or spiritual issues important in your life? _____Yes _____No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? _____ Yes _____ No

If yes, what are they? _____

Who referred you to Restore Hope Counseling?

_____

How would you rate your health? _____

How many hours do you sleep each night? _____

Do you experience food cravings? _____ Yes _____ No

If so, for what items? _____

How would you rate your diet?

____ Very Healthy ____Healthy ____Average ____Needs Improvement ____Poor

Are you currently on medication? _____ Yes _____ No

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS:

What are you seeking help for? _____

_____

How much are you troubled by this?

_____ Constantly _____ Often _____Somewhat _____ Not Very Much

Comments concerning this problem: _____

_____

Have you been in counseling before? _____Yes _____ No
If so, for each incidence you remember, please complete the following (use back of this page if needed.)

1. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

2. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

3. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2. I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3. No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4. I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5. Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6. I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7. I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8. I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently

9. I am going crazy. ____ Never ____Rarely ____ Sometimes ____ Frequently
10. I can't concentrate. ____ Never ____Rarely ____ Sometimes ____ Frequently
11. I am so depressed. ____ Never ____Rarely ____ Sometimes ____ Frequently
12. God is disappointed in me. ____ Never ____Rarely ____ Sometimes ____ Frequently
13. I can't be forgiven. ____ Never ____ Rarely ____ Sometimes ____ Frequently
14. Why am I so different? ____ Never ____ Rarely ____ Sometimes ____ Frequently
15. I can't do anything right. ____ Never ____ Rarely ____ Sometimes ____ Frequently
16. People hear my thoughts. ____ Never ____ Rarely ____ Sometimes ____ Frequently

17. I have no emotions. ____ Never ____ Rarely ____ Sometimes ____ Frequently
18. Someone is watching me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
19. I hear voices in my head. ____ Never ____ Rarely ____ Sometimes ____ Frequently
20. I am out of control. ____ Never ____ Rarely ____ Sometimes ____ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like them to take place.

____ Aggression	____ Fatigue	____Sexual Difficulties
____ Alcohol Dependence	____ Hallucinations	____ Sick Often
____ Anger	____ Heart Palpitations	____ Sleeping Problems
____ Antisocial Behavior	____ High Blood Pressure	____ Speech Problems
____ Anxiety	____ Hopelessness	____ Suicidal Thoughts
____ Avoiding People	____ Impulsivity	____ Thoughts Disorganized
____ Chest Pain	____ Irritability	____ Trembling
____ Depression	____ Judgment Errors	____ Withdrawing
____ Disorientation	____Loneliness	____ Worrying
____ Distractibility	____ Memory Impairment	____ Other (Specify)

____ Dizziness	____ Mood Shifts	_____
____ Drug Dependence	____ Panic Attacks	_____
____ Eating Disorder	____ Phobias/Fears	_____
____Elevated Mood	____ Recurring Thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (I.g., socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary. _____

_____

_____

_____

_____

_____

Whom should we contact in case of emergency?

Name _____

Address _____

Home Phone _____ Work Phone _____

RESTORE HOPE COUNSELING AT FBC EASTLAND
LIMITATIONS OF CLIENT-THERAPIST
CONFIDENTIALITY

Confidentiality is of the utmost importance where the client-therapist relationship is concerned. We believe that it is important that the client be able to assume that their private communications with the therapist be kept private. However, there are certain exceptions which supersede the confidentiality of the client-therapist relationship. It is our ethical obligation to inform you of the exceptions.

Exceptions to Confidentiality:

1. The therapist makes an assessment of an impending suicide risk. (Chapter 611, Family Code)

2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person. (Chapter 261, Family Code)

3. A client acknowledges committing abuse or neglect of a child, elderly person or mentally challenged person either in present or in the past. (Chapter 261, Family Code)

4. There is a probability of imminent harm to the client or others. [Chapter 611, Sec. 004(a)(2) Health and Safety Code]

5. Counseling records may be released when they are subpoenaed by a court of law.

I have read the preceding statement and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my therapist is bound ethically and legally to inform the proper authorities.

Client Signature: _____ Date: _____

Client Name: _____

Witness Signature: _____

Witness Name: _____

RESTORE HOPE COUNSELING AT FBC EASTLAND
INFORMED CONSENT

I understand that counseling may involve discussing relationship, spiritual, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am further aware that the Restore Hope Counseling is a faith-based ministry affiliated with First Baptist Church of Eastland. I am aware that there are alternative treatment facilities available to me.

My therapist has satisfactorily answered all of my questions about counseling at FBC Eastland. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with the therapist.

In signing this form:

a) I understand and agree to the services at this center being provided by doctoral or master's level, licensed or intern, counselors. This may include case consultation and review of treatment notes.

b) I understand the confidentiality policies of Restore Hope Counseling and I agree to them.

c) I understand that my role as a client is:
1) To be honest during counseling sessions, complete homework assignments, and demonstrate a willingness to change.
2) To refrain from the use of alcohol or drugs prior to a counseling session.

d) I understand and agree to the fee structure for counseling services.

e) I understand that failure to provide 24 hours notice when canceling an appointment will result in fees charged for the full session.

I have read this Professional Disclosure Statement, and my questions about it have been answered to my satisfaction. I understand that information about my case might be shared with the counselor trainee's supervisor for training purposes, but that the trainee will preserve my anonymity and confidentiality when consulting with others about my case. My signature below verifies my informed consent for participation in counseling sessions with the counselor trainee under the conditions that are described in this document.

_____

Client Signature Date

Site Supervisor Information

Name and Credentials:
Steve Queen LPC-S, Director of Ministry of Counseling and Enrichment, Clinical Supervisor
Texas License Number 17066

Contact Information-Ministry of Counseling and Enrichment
1502 N 1st Street
Abilene, TX 79601
Phone: (325) 672-9999
Email: steve@ministrycounseling.com

Client Signature _____

Client Name _____ Date _____

Witness Signature _____

Witness Name _____

Payment Agreement: _____ Paid:_____

RESTORE HOPE COUNSELING AT FBC EASTLAND
CLIENT EMERGENCY CONTACT INFORMATION

Client Name: _____

Home Telephone Number: _____
May we contact the client at this number? _____ Yes _____ No
May we leave a message? _____ Yes _____ No

Cell Phone Number: _____
May we contact the client at this number? _____ Yes _____ No
May we leave a message? _____ Yes _____ No

Work Phone Number: _____
May we contact the client at this number? _____ Yes _____ No
May we leave a message? _____ Yes _____ No

Home Address:
_____

_____

May we write the client at this address? _____ Yes _____ No

Who else lives at this address? _____

_____

EMERGENCY INFORMATION

Medical Conditions: _____

_____

_____

Medications: _____

_____

Emergency Contact Information

Name: _____

Relationship to Client: _____

Telephone Number: _____

RESTORE HOPE COUNSELING AT FBC EASTLAND

405 S. Seaman St
Eastland, TX 76448
254-629-3355

COUNSELING SERVICES INFORMATION

Who We Are

Restore Hope Counseling is a faith-based ministry affiliated with First Baptist Church of Eastland. Restore Hope Counseling is committed to providing counseling that is based on Christian principles in a comfortable, confidential atmosphere with Christian counselors who integrate therapeutic skills with a solid biblical foundation.

Restore Hope Counseling has Master's level Counselors in order to offer a variety of counseling services. We are here to serve individuals and their families associated with FBC Eastland as well as the community at large. Services are provided by licensed and intern trained counselors. Interns are under direct supervision of other therapists or psychologists who are licensed by one or more of the following:

Texas State Board of Examiners of Psychologists 512-305-7700
Texas State Board of Examiners of Professional Counselors 512-834-6658
Texas State Board of Examiners of Marriage and Family Therapists 512-834-6657
Texas State Board of Social Worker Examiners 512-719-3521

(The above Texas State Boards receive questions and complaints regarding services by licensed professionals at the indicated numbers. Services are available to the hearing and speech impaired through Relay Texas: 1-800-735-2989.)

Confidentiality

It is important for you to understand that all identifying information about your counseling therapy/treatment is kept confidential. Even within the church, information regarding your case is only shared with those professionals (i.e., supervisors and consultant counselors) who will confer with your service provider and thereby enhance the services you receive.

In order to protect client confidentiality, we adhere to the following procedures:

1. Written, telephone, or personal inquiries about clients will not be acknowledged without permission. You must sign a release before any information about you is given to anyone outside the counseling center. Even then we may advise you to withhold information if we feel it is in your best interest.

2. All records, tapes (if apply) or other identifying materials are kept

confidential.

3. Recordings (if made) are routinely erased and records are destroyed on a regular basis as provided for in Texas law.

4. Legal limits to confidentiality are observed.

Service Policy

Calls placed to FBC Eastland counselors will be primarily for the purpose of scheduling or rescheduling appointments. Non-emergency calls placed to the counselors will be returned within 24 hours Monday through Thursday. Calls placed Friday through Sunday will be returned by the following Monday. In emergency situation (i.e., situations where someone is out of control, has ideas or plans of self harm or of harming others, or demonstrates potentially harmful behavior) the client should dial 911 or go directly to the nearest hospital emergency room.

When a cancellation of a counseling session is unavoidable, it is important for the client to notify the counselor 24 hours in advance. *Failure to provide 24 hours notice when canceling an appointment will result in fees charged for the full session*. Consistently missed appointments (barring bona fide emergencies) or failure to complete counseling homework assignments on a regular basis may result in termination of the counseling relationship.