

For counselor use only

|                                  |                               |
|----------------------------------|-------------------------------|
| Intake Date:                     |                               |
| Counselor:                       |                               |
| Fee:                             | Previous client: yes<br>or no |
| Dates of<br>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.

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## SYMPTOMS

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Aggression          | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Sexual Difficulties   |
| <input type="checkbox"/> Alcohol Dependence  | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Sick Often            |
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Heart Palpitations  | <input type="checkbox"/> Sleeping Problems     |
| <input type="checkbox"/> Antisocial Behavior | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Suicidal Thoughts     |
| <input type="checkbox"/> Avoiding People     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Thoughts Disorganized |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Judgment Errors     | <input type="checkbox"/> Withdrawing           |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Memory Impairment   | <input type="checkbox"/> Other (Specify)       |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Mood Shifts         | _____  |
| <input type="checkbox"/> Drug Dependence     | <input type="checkbox"/> Panic Attacks       | _____  |
| <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Phobias/Fears       | _____  |
| <input type="checkbox"/> Elevated Mood       | <input type="checkbox"/> Recurring Thoughts  | _____  |

**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: \_\_\_\_\_





**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:

\_\_\_\_\_  
\_\_\_\_\_

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.

