

**HOPE BIBLICAL COUNSELING SERVICES**  
**ADULT INFORMATION FORM**  
(PLEASE PRINT)

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

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

May we write to you at your home?  Yes  No

May we leave a message at the following numbers? Home: \_\_\_\_\_  Yes  No

Cell Phone: \_\_\_\_\_  Yes  No Work: \_\_\_\_\_  Yes  No

Email: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex:  Male  Female

Occupation - Self: \_\_\_\_\_ Spouse: \_\_\_\_\_

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

**EDUCATION**

Self:  GED  High School Diploma  College Degree  Graduate Degree

Degree Obtained \_\_\_\_\_

Spouse:  GED  High School Diploma  College Degree  Graduate Degree

Degree Obtained \_\_\_\_\_

Children: Name	Gender	Age	Father's/Mother's First Name
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____

**PERSONAL INFORMATION:**

Are you currently attending church?  Yes  No If so, where? \_\_\_\_\_

Are you a born-again Christian?  Yes  No  Unsure

Briefly describe your relationship with Christ:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are religious or spiritual issues important in your life?  Yes  No

Are there any religious or spiritual resources in your life that could be used to help you overcome your problems?

Yes  No If so, what are they? \_\_\_\_\_

How were you referred to Hope? \_\_\_\_\_

How would you rate your overall health?  excellent  good  fair  poor

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:

<i>Medication</i>	<i>Dosage</i>	<i>Physician</i>	<i>Purpose</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PERSONAL CONCERNS:**

What is your main concern that brought you in today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much are you troubled by this?  Constantly  Often  Somewhat  Not Very Much

Comments concerning this problem:

\_\_\_\_\_

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**PREVIOUS COUNSELING HISTORY:**

Have you received Biblical Counseling Services at Hope before? ( ) Yes ( ) No

Who was the counselor? \_\_\_\_\_

What was the main concern?

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**Please list all previous counselors prior to coming to Hope:**

Who was the counselor? \_\_\_\_\_

What was the main concern?

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Who was the counselor? \_\_\_\_\_

What was the main concern?

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Who was the counselor? \_\_\_\_\_

What was the main concern?

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**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  | _____  |

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

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Whom should we contact in case of an emergency?

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**THANK YOU FOR CHOOSING  
HOPE BIBLICAL COUNSELING SERVICES**

# HOPE BIBLICAL COUNSELING SERVICES

## INFORMED CONSENT

### COUNSELING RELATIONSHIP

We appreciate the fact that you have chosen Hope Biblical Counseling Services to walk with you through the counseling process. We recognize that your participation is voluntary and know that you have the right to terminate at anytime. However, our goal for you is for full participation so that you may gain the most out of the counseling process. This includes consistent attendance, being on time and ready to go at the start of each session with your homework already completed. We trust that your commitment to these essentials of counseling will help play a valuable role in bringing about the change that you so desire.

Furthermore, we are completely committed to walking alongside you as you seek out change from a biblical perspective that ultimately draws you closer to God. As part of that commitment, it is extremely important to note that God is the only one that can and will cause true change. Our hope is not in ourselves or a technique but our hope is in the Lord to work through us and in your heart in order to cultivate genuine Christ-like change.

### COUNSELING APPROACH

The counselor takes a Cognitive-behavioral approach from a Biblical foundation. Most of the counseling process will focus around change coming from this perspective. The related risk follows if the client does not see change from this perspective and then proceeds to move forward with counseling. It is important to note that even though we believe strongly in incorporating Scripture and prayer in the counseling session, we will not impose our beliefs on the client that does not share this same value.

### CONFIDENTIALITY

We are obligated legally and ethically to keep any of the information that you share with us private and confidential. Limits to confidentiality are listed below:

The counselor determines the client is a danger of harming himself/herself or someone else.

The client discloses abuse or neglect of a child, elderly or disabled person.

The client authorizes the counselor to release records.

The counselor or counseling records are summoned or subpoenaed by a court of law.

The counselor becomes aware of an ethical violation by another mental health professional.

Weekly supervision as required by the Texas State Licensing Board with Dr. Steve Hunter, LPC, LPC-S, NCC who is credentialed in overseeing Licensed Professional Counselor (LPC) Interns. During supervision, the progress of each client may be discussed in order to provide the very best care for the client.

### APPOINTMENTS

Biblical Counseling Services will make a special effort to make sure that the counseling sessions start on time. As a result, it is our expectation that you will share this expectation with us which will help start and end sessions on time. Here are a few important things to know about your appointment:

Each appointment is typically 50 minutes long and ranges from 4-6 sessions for counseling to be most effective.

In case you are running late to an appointment, please call but know that your appointment will still end at the specified time.

If an appointment needs to be cancelled or rescheduled, please be courteous to give your counselor a 24 hour notice.

Please make sure that all cell phones are turned off during the session to maximize the time allowed for counseling. The counselor will adhere to this policy as well.

## **AFTER HOURS/EMERGENCIES**

Biblical Counseling Services hours are Monday through Friday 8am to 6pm. In case of an emergency after hours please call your primary care physician, 911, your local hospital, or a suicide hotline: 214.828.1000 or 1.800.784.2433 for immediate assistance. Please know that we will make every effort to return messages and emails the next business day.

## **RISKS OF COUNSELING**

It is important for the client to know going into the session where the counselor stands in regard to the results from counseling. Although it is the full desire of the counselor to help the client and see true change, it must be understood that there are no guarantees for the client to get the results that they desire. During the counseling process, you may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from counseling. Our hope and desire is for true change to take place that gets to the heart of the issue resulting in long term change.

## **ETHICAL GUIDELINES**

The counselor holds to a strong view of Christian ethics in and out of the counseling session. The counselor also operates under the Code of Ethics set by the American Association of Christian Counselors. A copy of the AACC code of ethics will be provided upon request.

## **DISPUTES AND COMPLAINTS**

The goal of counseling is to help the client bring about true change. In order to help limit disputes, please read over the policies thoroughly. The counselor will do his/her best to ensure that the correct procedures are being followed. If there is a dispute or complaint please see the counselor in a calm manner in order to bring about resolution. If further information is needed, please contact the Texas State Board of Examiners of Professional Counselors.

## **FEES AND CHARGES**

Currently there are no fees associated with the counseling that is provided by Biblical Counseling Services. However, if you would like to give back to the ministry we would gladly accept a donation of any amount as we continue to serve those in need of biblical counseling.

## CONSENT FOR COUNSELING SERVICES

I, the undersigned, do hereby release from any and all legal action as a direct or indirect result of any involvement I may have with Hope Biblical Counseling Services.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**If the client is under 18, I, \_\_\_\_\_ (please print), have legal custody and give my consent for counseling of the below named minor.**

Client or Guardian

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

Client or Minor

Printed Name: \_\_\_\_\_