There's Hope! Counseling Services
1421 S. Boston
Tulsa, OK 74119
(918) 277-0777

Please complete the following. Thank you for your assistance.

Date_______________________

CLIENT INFORMATION

Client Name____

Address ____

City_____________________________________ State__________________ Zip Code________________________

Home Phone________________________________ Cell / Wk Phone ______________________________________

Birthdate_____________________________ Social Security Number______________________________________

Occupation_________________________________Place of Employment___________________________________

Education (Highest Grade Completed)______________________ Marital Status______________________________

Religious Affiliation____

SPOUSE OR PARENT INFORMATION (If applicable)

Name____

Address ____

City_____________________________________ State__________________ Zip Code________________________

Home Phone________________________________ Cell / Wk Phone ______________________________________

Birthdate_____________________________ Social Security Number______________________________________

Occupation_________________________________Place of Employment___________________________________

Education (Highest Grade Completed)______________________ Marital Status______________________________

Religious Affiliation____

CHILDREN/SIBLINGS

Name	Birthdate/Ages	Grade in School	Living at Home

Whom should we contact in case of an emergency?____

Telephone Number_________________________________ Relationship___________________________________

Should we need to call to confirm appointments or gather additional information, is it acceptable to leave messages on recorder or with whomever answers the phone? Please comment.

____

Whom may we thank for referring you to us?____

See reverse side

1. Briefly describe the problem for which you are seeking help.

____

____

2. How do you think we can best assist you?

____

____

3. Who is your personal physician/pediatrician? ____

4. When was your last physical examination? ____

5. Please describe any physical disabilities or major health problems.

____

____

6. Please list any medications you or your child are now taking.

____

____

7. Please describe any additional information that might be helpful in our understanding of the problem.

____

____

8. Have you or your child received psychiatric help or psychological counseling before? (Circle)YES NO

If yes, with whom and dates? ____

____

Please circle any of the following symptoms/problems that pertain to you or your spouse:

Nervousness	Depression	Fears or phobias	Suicidal thoughts
Shyness	Sexual problems	Separation/divorce	Weight
Having to do things over and over	Coping with a traumatic event	Thoughts I can't get out of my mind	Need to be in control of everything
Finances	Alcohol or drug use	Career choices	Friends
My past	Stomach troubles	Dependency	Relationship problems
Anger/temper	Self-control	Unhappiness	Sleep
Stress	Children	Bowel problems	Headaches
Tiredness	Legal matters	Memory	Lack of ambition
Energy	Insomnia	Making decisions	Loneliness
Procrastination	Education	Inferiority feelings	Concentration
Unresolved grief	Loss of control	Health problems	Nightmares
Marriage	Work	Appetite	Blocked emotions
Being a parent	Unresolved grief	"Up-and-down" Feelings	Relaxation