



## There's Hope! Counseling Services

7146 S. Braden Ave., Suite #100

Tulsa, OK 74136

(918) 277-0777

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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 \_\_\_\_\_ Email address: \_\_\_\_\_

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 \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Education (Highest Grade Completed) \_\_\_\_\_ Marital Status \_\_\_\_\_

Religious Affiliation \_\_\_\_\_

### CHILDREN/SIBLINGS

<u>Name</u>	<u>Birthdate/Ages</u>	<u>Grade in School</u>	<u>Living at Home</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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? \_\_\_\_\_

May we send the person responsible for your referral a "thank you" note? \_\_\_\_\_

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

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

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3. Who is your personal physician/pediatrician? \_\_\_\_\_

4. When was your last physical examination? \_\_\_\_\_

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

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6. Please list any medications you or your child (whoever is being seen) are now taking.

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

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

If yes, with whom and dates? \_\_\_\_\_

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**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



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***CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY***

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

\_\_\_\_\_ 1) Confidentiality – I am aware that all information is confidential and cannot be released without my written permission. I have also been informed of exceptions when confidential information could be released including when imminent danger is a risk for self or others, child abuse, elder abuse, or when ordered by the court.

\_\_\_\_\_ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf. I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

\_\_\_\_\_ 3) Client Right & Responsibilities – I acknowledge that I have read my client rights and responsibilities.

\_\_\_\_\_ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged the full amount for that appointment.

\_\_\_\_\_ 5) Professional Consultation - I am aware that my therapist may consult or share information with other mental health professionals with expertise if such consultation can be expected to be beneficial in therapeutic treatment. I am also aware that these professionals are under the same confidentiality restraints as my therapist and my identity will not be disclosed and my right to privacy will remain respected.

\_\_\_\_\_ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

\_\_\_\_\_ 7) Court Testimony and Custody Evaluations – I am aware that There's Hope! Counseling Services make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact a There's Hope! Counseling Services therapist personally or via my attorney to testify in court.

\_\_\_\_\_ 8) I do \_\_\_\_\_ do not \_\_\_\_\_ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to participate in evaluation and or treatment with the therapist identified below.

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

\_\_\_\_\_ Therapist \_\_\_\_\_ Date

## **There's Hope! Counseling Business Policies**

Our experience has been that counseling and psychotherapy are most effective when expectations regarding fees, billing, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

### FEES

For individual, couples, marital, and family therapy (most sessions are 50 minutes in length. Longer or shorter sessions may be recommended in certain circumstances):

Initial 50-minute <b>Intake</b> assessment .....	\$150.00
50-minute <b>Individual</b> session .....	\$125.00
50-minute <b>Couples</b> or <b>Family</b> session .....	\$150.00

Should these fees put a financial hardship on you, please consult with your therapist regarding a sliding scale fee based on income.

### PAYMENT

All payments are due at the time of service. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of therapy if the former client fails to make a reasonable effort to pay off any outstanding balance.

### CANCELLATIONS AND MISSED APPOINTMENTS

If you cannot keep an appointment, please notify our office at least 24 hours in advance so that we can reschedule someone else for the time that has been reserved for you. Unless we are able to reschedule with shorter notice, the regular fee will be charged for appointments missed without notice or canceled with less than 24 hours notice. There is no charge for appointments canceled due to illness or emergency if the office is notified prior to the scheduled appointment time.

My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above. I agree to assume financial responsibility for the cost of services rendered by There's Hope Counseling Services to me or to the person whose name appears below.

Client: \_\_\_\_\_ Client Date of Birth: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_



**There's Hope! Counseling Services**  
**Kim Thomas, LPC, LMFT**  
**7146 S. Braden Ave., Suite #100**  
**Tulsa, OK 74136**  
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## ADULT HISTORY AND GOALS QUESTIONNAIRE

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Please complete this questionnaire and give to your therapist at your initial appointment. This information will help your clinician gain an understanding of the problems for which you are seeking help and other important events in your life.

YOUR NAME IN FULL	DATE OF BIRTH	AGE
SPOUSE'S NAME IN FULL	DATE OF BIRTH	AGE
WHO REFERRED YOU TO US?	TODAY'S DATE	

WHAT EMOTIONAL, BEHAVIORAL, OR INTERPERSONAL PROBLEMS ARE YOU EXPERIENCING THAT ARE CAUSING YOU TO SEEK THERAPY AT THIS TIME?

.....

.....

IF APPLICABLE, DESCRIBE HOW THE PROBLEMS ARE INTERFERING WITH WORK OR SCHOOL PERFORMANCE, FAMILY LIFE, SOCIAL LIFE, AND RELATIONSHIPS	HOW LONG HAVE THESE PROBLEMS BEEN AFFECTING YOUR LIFE?
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DESCRIBE ANY STRESSFUL CIRCUMSTANCES THAT MAY BE CONTRIBUTING TO THESE PROBLEMS

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WHAT HAVE YOU DONE TO SOLVE THE PROBLEM?

.....

HAVE ANY OF THESE SOLUTIONS BEEN HELPFUL?
<input type="checkbox"/> YES <input type="checkbox"/> NO

### PREVIOUS TREATMENT

HAVE YOU RECEIVED PREVIOUS TREATMENT FOR THESE PROBLEMS?  YES  NO (describe below)

DATE	NAME OF FACILITY OR PROFESSIONAL WHO PROVIDED TREATMENT	TYPES OF TREATMENT	RESPONSE

WHAT DID YOU FIND MOST HELPFUL ABOUT YOUR PREVIOUS TREATMENT?

WHAT WAS LEAST HELPFUL ABOUT YOUR PREVIOUS TREATMENT?

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## EDUCATION AND EMPLOYMENT

LIST ANY RECENT CHANGES

DESCRIBE PLANS YOU HAVE TO MAKE CHANGES

EDUCATION:

DID NOT COMPLETE  
HIGH SCHOOL

COMPLETED HIGH SCHOOL

COMPLETED BUSINESS /  
TECHNICAL TRAINING

COMPLETED COLLEGE

COMPLETED  
GRADUATE SCHOOL

OCCUPATION

HOMEMAKER

TECHNICAL /  
TRADE

SALES

CLERICAL

OTHER

PROFESSIONAL

UNEMPLOYED

YEARLY INCOME \$ \_\_\_\_\_

MILITARY SERVICE:

YES  NO

IF YES, WHAT BRANCH?

HIGHEST RANK

TYPE OF DISCHARGE

## MEANING AND SPIRITUALITY

WHAT GIVES YOUR LIFE MEANING?

IS SPIRITUALITY OR RELIGION A SIGNIFICANT PART OF YOUR LIFE?

YES  NO

DO YOU PARTICIPATE IN  
A SPIRITUAL COMMUNITY?

YES  NO

WHAT RELIGION OR  
DENOMINATION DO  
YOU IDENTIFY WITH?

HOW ACTIVE ARE YOU THIS COMMUNITY?

HOW CAN YOUR BELIEFS, VALUES, OR PRACTICES HELP YOU OVERCOME THE PROBLEMS THAT BRING YOU INTO TREATMENT?

## OTHER IMPORTANT INFORMATION

IF APPLICABLE, DESCRIBE ANY FINANCIAL DIFFICULTIES YOU ARE HAVING

IF APPLICABLE, DESCRIBE ANY PAST OR CURRENT LEGAL PROBLEMS

LIST WHAT YOU DO FOR FUN OR RECREATION

HOW MANY CLOSE FRIENDS DO YOU HAVE?

ARE YOU SATISFIED WITH THIS NUMBER?

YES  NO

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE ME TO KNOW REGARDING YOUR REASON FOR CHOOSING TO COME INTO THERAPY?