HOPE FOR NORTH BREVARD, INC.

Hope Counseling Center

416 Pine Street, Titusville, FL 32796

Phone: 321-863-6357 Web: hopenb.org

General Information

Today's Date:_____

Full Name: ___Mr. ___Mrs. ___Miss ___Dr. ___Rev. _____

Nick Name/Name you prefer: _____ Sex: ___Male ___Female

Social Security Number: _____ Date Of Birth: _ _/ _ _/ _ _ _ _ Age: _____

If under 18, please complete the following:

Name of parent or guardian_____

Home Phone: (____) _____ Cell Phone: (____) _____

Contact Information

Street Address: _____ Suite/Apt #: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ___Yes ___No

Home Phone: (____) _____ May we leave a message here: ___Yes ___No

Cell Phone: (____) _____ May we leave a message here: ___Yes ___No

Work Phone: (____) _____ May we leave a message here: ___Yes ___No

Email Address: (____) _____ May we send a message here: ___Yes ___No

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (____) _____ Mobile Phone: (____) _____

Availability for appointments: Weekdays_____ Weekends_____

Mornings_____ Afternoons_____ Evenings_____

Employment Information

Employer: _____ Occupation: _____

Length of Employment: _____ Average Hours Worked Per Week: _____

Education Information

Last Year of School Completed: __9 __10 __11 __12 __GED College: __1 __2 __3 __4 Other: _____

Are you currently in school: __Yes __No If yes, what level/grade: _____

Medical Information

Primary Physician: _____ Phone: (_____) _____

Address: _____

List any current or recent (within 2 years) medical conditions, illness, surgeries, hospitalizations, etc. (use back sheet if necessary):

_____

_____

List all current medications you are taking (including those you seldom use—use back sheet if necessary):

Medication: _____ Dosage _____

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List any previous counseling, psychiatric treatment or in-patient care you have received (use back sheet if necessary):

Therapist: _____ Phone #: _____ Dates: _____ Reasons: _____

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Permission to contact previous counselor? (circle one) YES NO

How do you feel about the results of your previous counseling?_____

_____

Relational Information

Circle relational status: Single Dating Engaged Married Separated Divorced Widowed

Are you content with your current status: ___yes ___No

If married, how long: _____ Number of previous marriages for you: _____ For your partner: _____

If separated/divorced, how long: _____ If widowed, how long: _____

Is your partner supportive of you seeking counseling: ___Yes ___No ___Partner doesn't know ___N/A

Children- List your children (living or deceased)

Name	Sex	Current Age or Year of Death	Relationship to you (natural, adopted, step)	Living with you?	Describe Him/Her

Level of Distress

Indicate how distressed you are by placing and "X" on the scale below. (1= Very little distress; 10= Extreme Distress)

_____

1 2 3 4 5 6 7 8 9 10

Have you experienced suicidal thoughts (currently or in the past): ___Yes ___No

Physiological Symptoms

Please circle all of the following symptoms that apply to you presently or in the recent past:

Headaches	Dizziness	Stomach trouble
Visual trouble	Sleep trouble	Trouble relaxing
Weakness	Tension	Rapid heart rate
Difficulty breathing	Intestinal trouble	Tiredness
Change in appetite	Seeing Things	Pain
Hearing voices	Other: _____	

What is your height? _____ What is your weight? _____

How has your weight changed in the past 2-3 months? _____

Current Status

Please circle all of the following problems which pertain to you and/or your family:

Stress	*You / Family*	Nervousness	*You / Family*	Anxiety	*You / Family*
Panic	*You / Family*	Unhappiness	*You / Family*	Depression	*You / Family*
Guilt	*You / Family*	Apathy	*You / Family*	Terminal Illness	*You / Family*
Recent death	*You / Family*	Grief	*You / Family*	Hopelessness	*You / Family*
Inferiority feelings	*You / Family*	Defective feelings	*You / Family*	Loneliness	*You / Family*
Shyness	*You / Family*	Fears	*You / Family*	Friends	*You / Family*
Marriage	*You / Family*	Communication	*You / Family*	Phyiscal abuse	*You / Family*
Emotional abuse	*You / Family*	Verbal abuse	*You / Family*	Sexual abuse	*You / Family*
Temper	*You / Family*	Anger	*You / Family*	Aggressiveness	*You / Family*
Bad dreams	*You / Family*	Concentration	*You / Family*	Racing Thoughts	*You / Family*
Unwanted thoughts	*You / Family*	Memory	*You / Family*	Loss of control	*You / Family*
Implusive behavior	*You / Family*	Self- Control	*You / Family*	Compulsivity	*You / Family*
Sexual problems	*You / Family*	Pregnancy	*You / Family*	Abortion	*You / Family*
Legal matters	*You / Family*	Trauma	*You / Family*	Eating problems	*You / Family*
Drug use	*You / Family*	Alcohol use	*You / Family*	Trouble with job	*You / Family*
Career choices	*You / Family*	Ambition	*You / Family*	Making Decisions	*You / Family*
Children	*You / Family*	Being a parent	*You / Family*	Finances	*You / Family*

Other: _____

Please describe why you are coming to counseling (i.e. explain problems, issues):

_____

_____

What do you hope to gain or change by coming to counseling: _____

_____

Religious Background

Do you regularly attend church: ___Yes ___No If yes, where: _____

Name of your Pastor, Priest or Spiritual Leader: _____

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STATEMENT OF POLICIES AND PROCEDURES

Hope Counseling Center is a ministry of Hope for North Brevard, a Christian, non-profit organization that exists to offer outreach, mercy and counseling to the North Brevard community. Hope Counseling Center is also in partnership with Crosswalk Community Church and networked with several local churches. The purpose of Hope Counseling Center is to provide counseling with a distinctively Christian evangelical framework. The Center offers professional (fee based counseling) and psychotherapy to individuals, couples and families who seek help and healing.

COUNSELING SESSIONS

Counseling sessions are available weekly and are scheduled by appointment on the hour. Please make sure you arrive early to ensure a full length session. It is our policy to schedule you for a "standing appointment". Your counselor will confirm, at the end of each session, that you intend to come at the same time for your next appointment. If you need to come at a different time, ask your counselor, who will see if an alternative appointment time is available.

SERVICE FEES

The fee for a 50 minute counseling session is on a slide scale based upon annual income (*please see attached fee schedule*). At *Hope Counseling* we are committed to helping people and no one should feel turned away due to financial reasons. Hope Counseling also has partnered with local churches to provide diaconate financial support for counseling. If you are interested in applying for financial support for counseling through the help of your church, please ask for the available form to fill out. Payment is due at the end of each session and accounts must be kept current in order to continue counseling. ***Please make checks payable to" Hope for North Brevard, Inc.".***

CANCELLATIONS

If you must cancel your appointment, please call at least 24 hours before your scheduled appointment. It is your responsibility to contact your counselor to confirm your next appointment if you had to cancel or are a "no show". Please be aware that repeated cancellations or "no shows" will result in the loss of your standing appointment time.

CONFIDENITALITY

Hope Counseling Center is a safe and confidential place where struggles can be explored and healing can take place. All counseling records are strictly confidential. The center will not release counseling information without your consent, except where disclosure is required by law or by the ethics of the counseling profession (e.g., child abuse reporting, serious threat or harm to self or others). Therapists at Hope Counseling Center may also be meeting together and with licensed mental health professionals. A client's case may be discussed in order to ensure top quality care, but personal identity will be concealed.

I have read and understand the terms of service and accept the above statement of policies and procedures.

Signature: _____ Date: _____

Counselor: _____ Date: _____

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FEE SCHEDULE

*Please **circle** your fee amount, based upon annual income.*
You may be asked to show verification of your income (i.e. tax return, paycheck stub)

Salary	Fee Amount
Up to $24,999	$40.00
$25,000 -$39,999	$50.00
$40,000 - $55,000	$60.00
$55,000 - $69,999	$70.00
$70,000 & Up	$80.00

- For married clients combine income and use scale
- For pre-marital counseling, combine income & divide by two
- College Student fee: $35.00