

**Agape Psychological Consortium, PLLC  
Intake Form (Adults)**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Intake Date: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Gender: Female \_\_\_ Male \_\_\_ Race: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Primary language: \_\_\_\_\_

Marital Status (check all that applies): Single \_\_\_ Married \_\_\_ Partnered \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

If married or in a long-term relationship, partner's name: \_\_\_\_\_ Years together: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: NC Zip: \_\_\_\_\_

Phone (Primary): \_\_\_\_\_ (Phone Provider): \_\_\_\_\_ email: \_\_\_\_\_

**Reason(s) for seeking services (please be specific):**

Problem #1: \_\_\_\_\_

Problem #2: \_\_\_\_\_

➤ Type of services needed (please check one):  Therapy  Evaluation  Both  Consultation

➤ Previously seen at Agape Psychological Consortium:  Yes  No If yes, when: \_\_\_\_\_

**Counseling/Treatment Experiences:**

Currently Yes No When Previous Yes No When Hospitalization Yes No When

Has anyone else in your family been diagnosed or seen a therapist for emotional problems?  Yes  No

**Pertinent Developmental and Family History:**

List all family members, and "family-like", people living in the home:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other family members who are not in the home (e.g., sons, daughters):

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Location</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were there any unusual or traumatic experiences/events that seriously affected your life?  Yes  No

If yes, briefly describe: \_\_\_\_\_

Any history of abuse, neglect, or violence:  Yes  No

If yes, which type(s)? Sexual: \_\_\_ Physical: \_\_\_ Verbal: \_\_\_ Emotional: \_\_\_ Domestic Violence: \_\_\_

Any past or current DSS involvement:  Yes  No If yes, when: \_\_\_\_\_ Why: \_\_\_\_\_

**Psychiatric/Medical/Physical History:**

List any current health or physical concerns: \_\_\_\_\_

List any prescribed medications: \_\_\_\_\_

Any history of head injury  Yes  No If yes, when \_\_\_\_\_

Previous psychiatric hospitalizations:  Yes  No

Previous/Current psychiatric diagnoses (if any): \_\_\_\_\_

**Educational/Employment History:**

Last grade completed in school: \_\_\_\_\_

Have you ever been diagnosed with a learning disability or ADHD?  Yes  No

Have you ever received special education services or had an IEP?  Yes  No

If not a full-time student, are you currently employed?  Yes  No If not working, when last employed? \_\_\_\_\_

**Military History:**

Any military experience?  Yes  No If yes, branch of service: \_\_\_\_\_

Combat experience?  Yes  No If combat experience, where: \_\_\_\_\_

Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

**Legal Issues:**

Current legal problems?  Yes  No Current status: \_\_\_\_\_ On probation?  Yes  No  
Past legal problems:  Yes  No Charges: \_\_\_\_\_ Current status: \_\_\_\_\_

**Special Considerations:**

Currently seeking SSI or disability?  Yes  No  
Required by court, social services, or probation to have this appointment?  Yes  No  
Currently involved in any type of custody or child support dispute?  Yes  No

**Alcohol/Chemical Use History:**

Do you currently use alcohol or other non-prescribed drugs:  Yes  No  
Have you ever used alcohol or other non-prescribed drugs:  Yes  No  
Have you ever been in a treatment program for using alcohol or other non-prescribed drugs:  Yes  No  
Has anyone in your family had a problem with drugs or alcohol:  Yes  No

**Lethality History:**

Have you ever had thoughts of killing himself/herself?  Yes  No When: \_\_\_\_\_  
Have you ever attempted to commit suicide?  Yes  No When: \_\_\_\_\_ How: \_\_\_\_\_  
Have you ever had any thoughts about hurting others?  Yes  No When: \_\_\_\_\_  
Have you ever attempted to hurt someone else?  Yes  No When: \_\_\_\_\_ How: \_\_\_\_\_

**Treatment Plan:**

What things have you done so far to help with your current problem(s):  
a. \_\_\_\_\_ b. \_\_\_\_\_  
c. \_\_\_\_\_ d. \_\_\_\_\_

With each of your presenting problem, what specific goal(s) would you like to work on in therapy?  
Problem #1: \_\_\_\_\_  
Problem #2: \_\_\_\_\_

**Referral:** Who referred you to Agape Psychological Consortium?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
If known, name of practice or program: \_\_\_\_\_  
May I have your permission to thank this person for the referral?  Yes  No

**Your Medical Care:** If you were referred by a medical doctor, may we contact him/her so that he/she can be fully informed of your care and to coordinate your treatment?  Yes  No If yes, complete the following:

➤ Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
➤ Name of Practice: \_\_\_\_\_ Address: \_\_\_\_\_

**Emergency Contact:** If for some unforeseen reason, you have an emergency and someone needs to be contacted, may we contact this person to coordinate your care?  Yes  No If yes, complete the following:

Emergency Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Authorization:**

As legal guardian of this particular adult client, I have the legal authorization to give Agape Psychological Consortium permission to:

- Provide evaluation/therapeutic services to this client:  Yes  No
- Provide appointment reminders by text and/or email:  Yes  No

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_