Staff: Client #:__________ Insur. Verified:_______ Registered:_______ Pic:______ Consent/PCP: _____ F/U Letter: _________

# Agape Psychological Consortium

## 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): ____________________ (Secondary): __________________ email: ___________________________________

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**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: ______________________

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**Counseling/Treatment Experiences:**

| | Yes | No | When | | Yes | No | When | | Yes | No | When |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Currently | ___ | ___ | ____________ | Previous | ___ | ___ | ____________ | Hospitalization | ___ | ___ | ___________ |

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

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**Pertinent Developmental and Family History:**

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

| Name | Relationship | Age |
|---|---|---|
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |
| ______________________________ | ____________________ | _____ |

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

| Name | Relationship | Age | Location |
|---|---|---|---|
| ______________________________ | ____________________ | _____ | _________________________________ |
| ______________________________ | ____________________ | _____ | _________________________________ |
| ______________________________ | ____________________ | _____ | _________________________________ |
| ______________________________ | ____________________ | _____ | _________________________________ |

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: __________________________

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**Medical/Physical History:**

List any current health or physical concerns: ______________________________________________________________

List any prescribed medications: ________________________________________________________________________

Any history of head injury❑ Yes ❑ No If yes, when ____________________________________________________________

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**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: ____________________

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**Legal Issues:**

Current legal problems? ❑ Yes ❑ No Current status: ____________________ On probation? ❑ Yes ❑ No

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**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

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**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

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**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: __________

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**Treatment Plan:**

What things have you done so far to help with your current problem(s):

a. ______________________ b. ______________________

c. ______________________ d. ______________________

Sources of strength and support that can help you with your presenting 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: ________________________________________

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**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

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**Your Medical Care:** If you were referred by a medical doctor, may w contact him/her so that he/she can be fully informed and we can 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 #: ____________________