

Agape Counseling Services, PLLC
217 N. Fifth Avenue, Ste.201
Wilmington, NC 28401

phone 910-251-7789
fax 910-251-7789
e-mail: agapecounsel@netzero.com

Welcome to our practice!

We're very pleased that you've chosen to entrust us with your care.

In order to ensure that we have all the necessary information to contact you, please complete the following information. In the course of our work together, if any of this information changes, be sure to notify us.

PATIENT/CLIENT INFORMATION:

(Name) (Marital Status)

(Street Address)

(City) (State) (Zip)

Soc. Sec. # Birth Date (M / D / Y)

() - () - X
Home Phone Bus. Phone

() - () -
Cell Phone Fax

e-mail

In the event of an emergency, whom should we contact?

(Name) (Relationship)

(Street Address)

(City) (State) (Zip)

() - () - X
Home Phone Bus. Phone

() - () -
Cell Phone Fax

e-mail:

How did you learn about our office? (If you were referred by a healthcare professional, please tell us her/his name)
If this is not your primary care physician, please tell us who is and how we might reach him/May we have your permission to discuss your evaluation and treatment with this referring professional and/or primary care physician?
_____ (please initial approval)

**May we have your permission to contact you at home? _____yes _____no work? _____yes _____no
Cell? _____yes _____no (please check appropriate line)**

Your Signature _____ Date_____

Please Tell Us About Yourself:

Marital Status: _____single _____separated...how long_____
_____married _____divorced...how long_____

Spouse's Name _____
Number of times married _____

Do you have any children/Step Children? List name, birthdates, sex, relationship, and whether they live at home.

Name	Birthdate	Sex	Relationship	At home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you employed?
Place of employment: _____
Occupation: _____

Please fill out the following information as it applies to you.

A. Counseling Information

Have been through counseling before? _____yes _____no
If yes, when? _____
Name of Therapist _____
For what reason? _____

Are you, or another family member, currently seeing a psychiatrist, psychologist, or another therapist?
If yes, please give us their name: _____
Please state which family member: _____
For what purpose? _____

B. Crisis Information

Are you having any current suicidal thoughts or feelings?
If yes, please explain _____

No _____
Are you having any anger-control problems, or feelings?
If yes, please explain _____

No_____

C. Medical Information:

Primary Care Physician _____
Address: _____

Phone# _____

Are you presently taking any medications? Yes____
No____

If so, please list medications and reasons for taking them

_____ for _____
_____ for _____
_____ for _____

Any problems with:

_____ Sleeping?
_____ Eating?
_____ Chronic Pain?
_____ Recent weight changes?

Any other medical concerns that you would like for us to know about?

D. Common Problem/Symptom Checklist:

0=none	1=mild	2=moderate	3=severe
___ marriage	___ divorce/separation	___ God/Faith	
___ child custody	___ substance abuse	___ Church/Ministry	
___ singleness	___ disability	___ grief/loss	
___ past hurts	___ sexual issues	___ work/career	
___ depression	___ codependency	___ addiction to pornography	
___ school	___ fear/anxiety	___ intimacy	
___ parents	___ loneliness	___ communication	
___ self-esteem	___ in-laws	___ aging/dependency	
___ stress	___ mood swings	___ weight control	
___ other _____			

Your Signature: _____

Insurance / Payment Information:

How are you planning to pay for this and future visits? Please indicate one of the following:

___ Insurance & Co-pay (In Network)
*Presently a provider for select Blue Cross/Blue Shield,
Cigna, Tri-Care, Medcost, HealthCare-Savings,
Medicaid and some EAP programs.

___ Out of network Insurance (client is responsible for co-pay and any non-reimbursement of
services provided by Agape Counseling Services, PLLC.

***PLEASE NOTE THAT CO-PAYMENTS ARE ACCEPTED IF YOUR DEDUCTIBLE HAS BEEN MET. AS A
COURTESY TO OUR CLIENTS, WE WILL GLADLY FILE INSURANCE CLAIMS, BUT YOU MUST BE
PREPARED TO PAY FOR YOUR OFFICE VISITS UNTIL THAT DEDUCTIBLE HAS BEEN MET.**

___ CASH ___ CHECK ___ CREDIT CARD

