

Agape Counseling Services, PLLC  
3725 Wrightsville Ave, Suite B  
Wilmington, NC 28403

phone 910-251-7789  
fax 910-251-7789  
e-mail: info@agape-counseling.org

**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.

