Agapé Counseling Center
700 S. 8th Ave.
PO Box 41
Brandon, SD 57005
(605)582-4722

Intake Paperwork

Date: ____ / ____ / ____

Full Legal Name: _____

Preferred Name: _____

Age: _____ DOB: ____/____/____ Sex: M ____ F____

Gender Identity (if applicable): _____

Race/Ethnicity: _____ Marital Status:_____

Religious / Spiritual Preference (if any): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: ____-____-____

Work Phone #: ____-____-____

Cell Phone #: ____-____-____

Email: _____

Is it ok to contact you and/or leave messages at the numbers and/or email above?
(Check all that apply)
Home Phone ____ Work Phone ____ Cell Phone ____ Email ____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone #: ____-____-____

Education Level / Current Grade: _____

Employer: _____ Position: _____

Length of Time at Current Employer: _____

Medical Information:

Primary Physician and/or Facility: _____

Psychiatrist (if applicable): _____

Please list any medications (prescription, over-the-counter, vitamins, etc.) you are currently taking:

_____

_____

Physician Information/Authorization: (if applicable)

I hereby authorize Agapé Counseling Center to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally advising my therapist.

_____ ____ / ____ / ____
Signature of Client (Parent/Guardian if minor) Date

Insurance Information:

Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's DOB: ____ / ____ / ____ Insurance Policy #: _____

Responsible Party for Copays / Billing: _____

Alternative Billing Address & Phone # (if applicable): _____

_____

If Client is a Minor:

Parent/Guardian's name: _____

Parent/Guardian's phone #: ____-____-____

Parent/Guardian's name: _____

Parent/Guardian's phone #: ____-____-____

By my signature below, I grant permission for Agapé Counseling Center to bill my insurance company as requested, to accept payment from my insurance company on my behalf, to share my billing information and intake information with Agapé secretarial staff, to share intake information with my insurance company or EAP provider, to contact my medical doctor as needed, and to provide counseling to my minor child as applicable.

_____
Printed Name of Client

_____ ____ / ____ / ____
Signature of Client (Parent/Guardian if minor) Date

_____ ____ / ____ / ____
Signature of Therapist Date

Help Us Get to Know You!

Who referred you to Agapé Counseling Center? _____

What is/are your primary reason(s) for coming to counseling? _____

_____

Have you had any previous mental health and/or substance use counseling? ___ Yes ___ No

If Yes, please describe: _____

What is/are your goal(s) for counseling? _____

_____

How will you know when you have reached your goals? _____

_____

How often would you like to meet with your counselor? _____

Are you currently having any suicidal thoughts and/or thoughts of self-harm? ___ Yes ___ No

If Yes, please describe: _____

Have you had any suicidal thoughts, had any suicide attempts, had any thoughts of self-harm, and/or harmed yourself physically in the past? ___ Yes ___ No

If Yes, please describe: _____

Anything additional you want your counselor to know about you? _____

_____