AGAPE
Love Works

CLIENT INFORMATION FORM

This form should be completed by the adult who will be responsible for the primary person receiving services. All information will be handled confidentially.

Client Name: _____Date_____
Please Print

Date of birth: _____ Gender: _____ Marital Status: _____

Email Address: _____

(Optional) Race/Ethnicity: Asian_____ Black/African American _____ Hispanic_____

White_____ Other_____

(Optional) Religious Preference _____

RESPONSIBLE PARTY (***If client is a minor*** *please provide parent or legal guardian information*)

Name: _____ Phone Number: _____

Date of birth: _____ Gender: _____ Marital Status: _____

Relationship to Client: _____

IN THE CASE OF AN EMERGENCY: Please contact: _____

Relationship to Client: _____ Phone _____

IF YOU ARE USING INSURANCE: Please give the receptionist your insurance card, if you haven't already, so we can make a copy for your file. Also, please remember that if at any point your insurance changes while you are a client here, you need to let us know.

EAP COMPANY: (if applicable) _____

EAP AUTHORIZATION #: _____ NUMBER OF SESSIONS: _____

AGAPE Client History

Please complete the following regarding the *individual who will be receiving counseling*. Use the back of the form if more space is needed. PLEASE USE BLACK INK ONLY.

Name of **person receiving counseling**: _____ Date: _____

Medical history (list major illnesses, hospitalizations, surgeries, etc.; include dates)

1. _____
2. _____
3. _____

History of counseling or psychiatric care:

	Provider (counselor or facility)	Approx. Dates	Nature of problem
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Family history of emotional, behavioral, psychological, or alcohol/drug problems:

	Family member (relationship to person seeking services at AGAPE)	Nature of problem
1.	_____	_____
2.	_____	_____
3.	_____	_____

Employment history (list major jobs beginning with most recent; include approximate dates)

1. _____
2. _____
3. _____

_____

Counselor's Notes:

AGAPE Client Symptom Rating Scale

Rate all symptoms below based on **the past month**. **Rate each symptom 0 - 5 according to symptom sev = symptom absent, 5 = symptom is extreme**. Your counselor will review and discuss your responses with during the intake interview. (Parents should complete form for child clients.)

Client Name: _____ Date:_____

Emotional Symptoms (Rate each symptom; circle 0 - 5)

Anger	0 1 2 3 4 5	**Anxiety**	0 1 2 3 4 5	**Extreme mood shifts**	0 1 2 3 4 5
Irritability	0 1 2 3 4 5	**Frustration**	0 1 2 3 4 5	**Helplessness**	0 1 2 3 4 5
Hopelessness	0 1 2 3 4 5	**Fear**	0 1 2 3 4 5	**Apathy**	0 1 2 3 4 5
Lack of emotions	0 1 2 3 4 5	**Guilt feelings**	0 1 2 3 4 5	**Depression**	0 1 2 3 4 5
Worry	0 1 2 3 4 5	Other (specify) _____			0 1 2 3 4 5

Mental Symptoms: (Rate each symptom; circle 0 - 5)

Problems with concentration	0 1 2 3 4 5	**Inattention**	0 1 2 3 4 5	**Memory problems**	0 1 2 3 4 5
Difficulty making decisions	0 1 2 3 4 5	**Distractibility**	0 1 2 3 4 5	**Racing thoughts**	0 1 2 3 4 5
Repeated unwanted thoughts	0 1 2 3 4 5	Other (specify) _____			0 1 2 3 4 5

Physical Symptoms: (Rate each symptom; circle 0 - 5)

Increase or decrease in appetite	0 1 2 3 4 5	**Sleep difficulties**	0 1 2 3 4 5
Tearfulness/crying spells	0 1 2 3 4 5	**Increased heart rate/pounding heart**	0 1 2 3 4 5
Sweating/chills	0 1 2 3 4 5	**Stomach or intestinal distress**	0 1 2 3 4 5
Frequent or severe headaches	0 1 2 3 4 5	**Body pain/numbness**	0 1 2 3 4 5
Muscle tension	0 1 2 3 4 5	Other (specify): _____	0 1 2 3 4 5

Behavioral Symptoms: (Rate each symptom; circle 0 - 5)

Hyperactivity	0 1 2 3 4 5	**Impulsivity**	0 1 2 3 4 5	**Withdrawal**	0 1 2 3 4 5
Arguing	0 1 2 3 4 5	**Disorganized**	0 1 2 3 4 5	**Self-injury**	0 1 2 3 4 5
Binge eating/ over eating	0 1 2 3 4 5	**Suicidal Gesture/attempt**	0 1 2 3 4 5	**Induced Vomiting**	0 1 2 3 4 5
Increased alcohol use	0 1 2 3 4 5	**Fighting/ Aggression**	0 1 2 3 4 5	**Oppositional Defiant**	0 1 2 3 4 5
Lying/ deceitfulness	0 1 2 3 4 5	**Avoidance of school or job**	0 1 2 3 4 5		

Other (specify) _____ 0 1 2 3 4 5

Notes (for counselor's use):

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Acknowledgement
of Agreement for Services
and HIPAA Notice

Your signature below indicates that you have received the **THERAPIST - CLIENT AGREEMENT** and agree to become an AGAPE client under the terms therein. This includes but is not limited to the points noted below. Please refer back to the **AGREEMENT** for more details or ask your counselor about anything that is unclear. By signing this form you:

1) acknowledge that you have been provided access to the HIPAA NOTICE form (a copy of the NOTICE is available at the check-in desk and is also posted in the waiting area)

2) permit AGAPE to disclose information about you and the services you were provided as necessary to process insurance claims or to collect overdue fees / payments from you

3) acknowledge your responsibility to inform AGAPE promptly of any changes in your insurance status or financial status that affects your coverage, benefits, co-payments, or fees. You acknowledge your responsibility for any fees/costs not covered by your insurance

4) acknowledge and understand that AGAPE staff must take action to protect serious threats to the life or safety of others. This will include reporting suspected abuse of a child or vulnerable adult, taking every reasonable step to prevent threats of violence against others from being carried out. You furthermore acknowledge that AGAPE will disclose information about you as necessary to comply with other legal requirements, such as responding to court -ordered releases of treatment records.

Print name of **patient/client** here: _____

_____ _____

Signature of patient / client (or parent / guardian) (Date)

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Financial Agreement

I understand that AGAPE requires payment before the counseling session begins. I will make sure I have the ability to pay before arriving.

I also understand that AGAPE has a **24-hour** Late Cancellation Policy. If I cancel an appointment after the 24-hour time frame, I will be charged $40 by my counselor. If it is due to a sudden illness or an emergency, the counselor will take this into consideration.

If I do not show up for a scheduled appointment I will be charged the $40 fee.

I understand this policy and agree.

_____

Printed Name

_____ _____

Signature Date

Revised 04/2018