1006 N Bowen Rd
Suite 200 D-H
Arlington, TX 76012
Phone: 817.460.1019

Founding Members
Manuel: 937.329.1298
Dr. Lucas: 740.802.4399
Fax: 817.394.5075

Agape Psych Services, PLLC

www.agapepsychservices.com

Confidential Client Information

Welcome to Agape Psych Services. We want to make the most of our services with you. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so or ask any questions you may have.

Person completing this document name: ______________________________

Identified patient name: ______________________________

Age: ________ Birth date: ______________ Birthplace: ____________________

SSN: ____________________

Address: ______________________________

City: ____________________ Prov/State: _______ Zip/Postal Code: ____________

Home phone: ____________________ Cell number: ____________________

Can voice messages be left? _________ Do you want text reminders for appointments? _____

Email address: ______________________________

Education (grade completed, any postsecondary): ______________________________

Current Occupation: ______________________________

Person to alert in the event of medical emergency: ______________________________

Relationship to you: ____________________ Phone: ____________________

Family Doctor: ____________________ Phone: ____________________

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Insurance/ Payor: ____________________________ Phone: ________________________________

Member # ______________________________ Group # _____________________________

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's name: _____________________________ **Age**: ___ **Yrs in relationship**: ___

Children (gender, age): ____

Please describe any significant current or past medical problems: ______________________________

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Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

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Have you had previous psychological care or counseling? ☐ **Yes** ☐ **No**

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

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____

Have you ever been hospitalized for a psychological difficulty? ☐ **Yes** ☐ **No**

If yes, please give the dates and the nature of the difficulty at the time: __________________

____

____

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Also list the goals you would like to achieve. Use additional paper if you like.

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Person completing this document signature:

_____________________________________ **Date:** _______________

Identified patient signature:

_____________________________________ **Date:** _______________