

Sarah Scott, MS, LPC Licensed Professional Counselor, #83253

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Patient Intake Form

		Today's date	
Personal Information			
Patient's name		Date of birth	
Address			
Street		Apt#	
City	State	Zip code	
Primary phone	Email		
Employer or school name			
Highest level of education comp	oleted or current grade/majo	r/field	
Emergency contact name		Relationship	
Emergency contact phone			
Referral's name			
Are you currently covered by M	edicaid or Medicare?	-	
Family Information			
Marital status (select one):			
Dates of marriage, divorce, dea	th of spouse, etc		
People currently living in house	hold (names/ages/relationsh	ips)	
Current nartner name (if releva	nt)	Δσρ	

Last Updated: 07/06/2022

History of relevant family events/stressors (e.g., adoptions, divorces, deaths, substance abuse):		
Biological family history of psychological issues (e.g., ADHD in sibli	ing, bipolar disorder in uncle):	
Medical Information		
Physician's name	Phone	
Reason for most recent visit	Date of visit	
Current medical condition(s)		
Current medications (name, dose, frequency)		
<u>Lifestyle Information</u>		
Current alcohol or drug use (type/frequency/duration at such free	quency)	
Previous alcohol or drug use (type/frequency/duration at such fre		

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Primary Concerns

Briefly describe the problems or concerns that bri	ng you here today:
<u>Previous Services</u>	
List previous therapies, treatment, tutoring, aca (including any substance use treatment).	demic accommodations, hospitalizations, etc
Therapist's name/agency/hospital	Dates or ages when received
Your signature below indicates that you consent Services Agreement).	t to treatment (see more details in Patient
Patient's printed name	
Patient's signature	Date

Last Updated: 07/06/2022