



**THE CONATIVE GROUP<sup>PC</sup>**  
— THINKING. FEELING. GROWING —

***Alana Tristan, MS, LPC***

**Licensed Professional Counselor #88071**

4130 Bellaire Boulevard, #208, Houston, TX 77025  
(713) 993-7030 | [alana.tristan@theconativegroup.com](mailto:alana.tristan@theconativegroup.com)

## **Patient Intake Form**

### **Personal Information**

Today's date \_\_\_\_\_

Patient's name \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Street

Apt #

City

State

Zip code

Grade \_\_\_\_\_ School name \_\_\_\_\_

Parent primary phone \_\_\_\_\_ Parent email \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency contact phone \_\_\_\_\_

Referral's name \_\_\_\_\_ Relationship \_\_\_\_\_

Is the patient currently covered by Medicaid or Medicare? \_\_\_\_\_

**Parent Information**

Mother's name \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_  
Street Apt #

City State Zip code

Father's name \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_  
Street Apt #

City State Zip code

Parents' marital status: \_\_\_\_\_

*If parents are divorced, and only one parent providing written consent to treatment, a copy of custody arrangements specific to authorization for medical/psychological treatment from divorce decree is required prior to beginning treatment.*

**Medical Information**

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist's name \_\_\_\_\_ Phone \_\_\_\_\_

Current medical condition(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications (name, dose, frequency) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family Information**

People currently living in household (names/ages/relationships) \_\_\_\_\_

\_\_\_\_\_

History of relevant family events/stressors (e.g., adoptions, divorces, deaths, substance abuse):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Biological family history of psychological issues (e.g., ADHD in sibling, bipolar disorder in uncle):

\_\_\_\_\_

\_\_\_\_\_

**Primary Concerns**

Briefly describe the problems or concerns that bring you here today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous Services**

List previous therapies, treatment, tutoring, academic accommodations, hospitalizations, etc.

Therapist's name/tutor's name/agency/hospital \_\_\_\_\_ Dates or ages when received \_\_\_\_\_

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*Your signature below indicates that you consent to treatment (see more details in Patient Services Agreement).*

Patient's printed name \_\_\_\_\_

Parent/guardian's name \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_