



Erin Whitney, M.A.

Licensed Professional Counselor Supervisor, 18109

Advanced Trainer – The Nurtured Heart Approach

4130 Bellaire Boulevard, #208

Houston, TX 77025

(713)993-7030

erin.whitney@theconativegroup.com

Patient Intake Form

Today's date _____

Personal Information

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 (circle):

Married

Separated

Divorced

Widowed

Never
married

Other

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 _____

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, evaluations, hospitalizations, tutoring, accommodations, etc.

Therapist'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 _____