Emily Blessinger, M.A.
Licensed Professional Counselor Intern #83706
Supervised by Catalina Prebisch, M.Ed., LPC-S, CART, CCTP
4130 Bellaire Boulevard, #208
Houston, TX 77025
(713)993-7030
emily.blessinger@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 _____

Are you 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, 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 _____