Patricia Hamilton, MS.
Licensed Marriage and Family Therapist, 78353
4130 Bellaire Boulevard #208, Houston, TX 77025
(713) 993-7030 | patricia.hamilton@theconativegroup.com

ADULTING PROGRAM 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 completed or current grade/major/field __________________________

Emergency Contact Name ___________________________________ Relationship _______________

Emergency Contact Phone ____

Referral's Name ____ Relationship _______________

Is the patient currently covered by Medicaid or Medicare? ______________

Family Information

Marital Status: ________________ Dates of marriage, divorce, death of spouse, etc.____________

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People currently living in household (names/ages/relationships) ____________________________

____

Current partner name (if relevant) _______________________________________ Age _________

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):

____

____

Recent Neuropsychological Evaluation

Evaluated by: ____ Date: __________________

Current Diagnosis: ____

Medical Information

Physician's name _______________________________________ Phone __________________

Reason for most recent visit ______________________________ Date of visit _______________

Current medical condition(s) ____

____

____

Current medications (name, dose, frequency) ____

____

____

Lifestyle Information

Current alcohol or drug use (type/frequency/duration at such frequency) ___________________

____

Previous alcohol or drug use (type/frequency/duration at such frequency) __________________

____

Primary Concerns

Briefly describe the problems or concerns that bring you to the Adulting Program:

____

____

____

____

____

____

Previous Services

List previous therapies, treatment, hospitalizations, tutoring, academic accommodations, etc. (including any substance use treatment).

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 ____

Patient’s signature ____ Date ____________________