Katherine Esquivel, MS, LPC-A
Licensed Professional Counselor Associate, #90147
Supervised by Roxanne Deams, LPC-S
4130 Bellaire Boulevard, #208, Houston, TX 77025
(713) 993-7030 | katherine.esquivel@theconativegroup.com | info@theconativegroup.com

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? SELECT ONE:

FamilyInformation

Marital status: SELECT ONE:

Dates of marriage, divorce, death of spouse, etc. _____

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):

_____

_____

Medical Information

Physician's name _____ Phone _____

Psychiatrist'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 here today:

_____

_____

_____

_____

_____

_____

Previous Services

List previous therapies, treatment, tutoring, academic accommodations, hospitalizations, 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 _____