Hope within Healing Counseling Services, PLLC

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Kingwood, TX 77339
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Patient Intake Form

Name: _____ SS#: _____ Date of Birth: _____

Age: ____ Gender: M F Non-Binary Transgender Man Transgender Woman Other:_____

Address: _____ City/State/Zip: _____

Employer/School: _____

Home Phone: _____ Cell: _____ Work: _____

Where do you prefer to receive calls? __Home __Cell __Work Can I leave a message? __Yes __No
May I contact you by e-mail: __Yes __No Email address: _____

Children living in the home:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

If client is a minor:

Mother's Name: _____ Home phone: _____
Work phone: _____ Cell phone: _____

Father's Name: _____ Home phone: _____
Work phone: _____ Cell phone: _____

Emergency Contact

Name: _____ Relationship: _____
Address: _____ Phone: _____

Health Information

Please list any medical conditions you feel the therapist should be aware of:

_____
_____
_____

Please list the medications the patient is currently taking, including the dosage:

_____
_____
_____