LIVINGSTON FAMILY CENTER

ADULT INTAKE INFORMATION

Date: _____

Legal Name: _____ Preferred Name: _____

Address: _____ City/Zip: _____

Best Phone Number: _____ ☐ Cell ☐ Home ☐ Work Alternative Number: _____

Date of Birth: _____ Age: _____ Religion/Spiritual Preference_____

Gender Identity: ☐ Male ☐ Female ☐Transgender Male/FTM ☐ Transgender Female/MTF ☐Other _____

What pronoun do you prefer that we use when talking about you? (Check all that apply)

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: please specify: _____

Relationship Status:☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Committed Relationship ☐ Other:_____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Employer/Occupation: _____ Military History: _____

Education: _____ Who referred you here: _____

What are your present symptoms and concerns? _____

_____

_____

_____

Client's Family Tree:

Relationship	Name	Age	Year Deceased (If applicable)	History of Mental Health	History of Substance Abuse
Mother					
Father					
Stepmother					
Stepfather					
Brother(s)					
Stepbrother(s)					
Sister(s)					
Stepsister(s)					
Spouse					
Ex-spouse					
Children					
Stepchildren					

ADULT INTAKE INFORMATION- Page 2

Medical History: Physician's Name: _____ Phone number: _____

Date Last Seen: _____ Height: _____ Weight: _____

List present illness and symptoms: _____

_____

_____

Medications: _____

Allergies: _____

Major illness, hospitalizations, accidents and surgeries: _____

_____

_____

Do you use alcohol or mood alerting drugs? Please explain. _____

_____

_____

List previous counseling or therapy:_____

_____

Do you have any sleep pattern concerns? If yes, please explain. _____

_____

What is stressful in your life? _____

_____

_____

What are your personal strengths? _____

_____

_____

Is there anything additional your therapist should know about you?_____

_____

_____

Please sign the Consent for Treatment and Acknowledgement of Privacy Notice on the next page.