LIVINGSTON FAMILY CENTER

ADULT INTAKE INFORMATION

Name: ______________________________ Date: ____________________

Address: ______________________________ City/Zip: ____________________

Phone: ____________Cell:____________ Work Phone: ____________

Gender: _______ Age: _______ Birth date: ____________ Religion (optional)____________

Birth Place: ____________ Marital Status: ____________ Education: ____________

Employer/Occupation: ____________________ Military: ____________________

Who referred you here: ____

What are your present problems and concerns? ________________________________

____

____

____

Client's Family Tree:

Relationship	**Name**	**Age**	**Year Deceased**	**City of residence**	**History of Mental Health or Substance Abuse. If yes, please specify.**
Mother					
Father					
Stepmother					
Stepfather					
Brothers					
Stepbrothers					
Sisters					
Stepsisters					
Spouse					
Children					
X-Spouse					
Stepchildren					

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? Which drugs? ______________________________________
____
____

List previous counseling or therapy: ____
____

Do you have any sleep pattern concerns? If yes, what are they? ________________________________
____

What is stressful in your life? ____
____
____

What else do you think your therapist needs to know about you? ______________________________
____
____

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