LIVINGSTON FAMILY CENTER

CHILD INTAKE INFORMATION

Name: _____ Date:_____

Address: _____ City/Zip: _____

Gender: _____ Age: _____ Birth date: _____ Religion: _____

Emergency contact name:_____ Relationship: _____

Address: _____ Phone: _____

School: _____ Grade: _____

How is your child doing in school? _____

_____

_____

What is YOUR description of this child's present difficulty? _____

_____

_____

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					

Child's Medical History: _____

_____

Physician's name:_____ Phone number: _____

Date of last check up? _____ Any hospitalizations?_____

Explain: _____

Medications: _____

Allergies: _____

Accidents/Injuries: _____

_____

Do you know or suspect that your child is using alcohol or mood alerting drugs? Which drugs? _____

_____

_____

Previous counseling or therapy? _____

_____

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

_____

What stressful life events has this child experienced, and when? _____

_____

_____

What else do you want us to know about your child?_____

_____

_____

Who has legal custody/ guardianship of the child? _____

Mother's Birth date _____ Religion (Optional) _____

Address _____ Home Phone #_____

Work Phone # _____ Cell Phone #_____ Education _____

Employer _____ Occupation _____

Father's Birth date _____ Religion (Optional) _____

Address _____ Home Phone # _____

Work Phone # _____ Cell Phone # _____ Education _____

Employer _____ Occupation _____

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