ALISON YOUNG THERAPY

Alison Young, MS, MFT
11500 West Olympic Blvd. Suite 615
Los Angeles, CA 90064
310-482-1199

Intake Form

NAME_____AGE _____ DATE OF BIRTH _____

ADDRESS _____CITY/ZIP _____

SOC.SEC.#_____DRIVER'S LIC.#_____

PRIMARY LANGUAGE _____ETHNICITY_____

HOME PHONE(_____)_____CELL PHONE(_____)_____EMAIL _____

BUSINESS PHONE(_____)_____NAME OF EMPLOYER_____

OCCUPATION_____

BUSINESS ADDRESS_____CITY/ZIP_____

EDUCATION/DEGREE_____

MARITAL STATUS___S___M___Sep___D___NAME & AGE OF CHILDREN_____

CURRENT LIVING SITUATION_____

DESCRIBE ANY HEALTH PROBLEMS_____

MEDICATIONS YOU TAKE & DOSAGE_____

DOCTOR'S NAME & PHONE NUMBER_____ (_____)_____

IN YOUR FAMILY, INCLUDING YOURSELF, WAS THERE:

ALCOHOLISM? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG?_____

RESOLVED?_____

SUBSTANCE ABUSE? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG?_____

RESOLVED?_____

MENTAL ILLNESS? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG?_____

RESOLVED?_____

SERIOUS ILLNESS? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG? _____

RESOLVED?_____

EMERGENCY CONTACT NAME/RELATIONSHIP _____

EMERGENCY CONTACT PHONE(_____)_____

IF THE CLIENT IS A MINOR, WHO IS THE LEGAL GUARDIAN?_____

HOW DID YOU HEAR ABOUT MY SERVICES?_____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

CLIENT:_____DATE:_____

LEGAL GUARDIAN:_____DATE:_____