Greg Whittaker MA, LMFT
8371 Church Street, Gilroy, CA 95020 | PHONE (408) 848-3331 | FAX (408) 848-3354

Name: _____ Today's Date: _____

Address: _____ City_____ Zip _____

Email: _____

SSN _____Age: _____ Birth date: _____

Home phone _____ Work Phone _____ Cell _____

Employed By: _____ May I call your work #? Yes /No Initial here _____

In Case of Emergency Notify: Name: _____ Phone _____

FOR MINOR CLIENTS

Mothers' Name: _____ Father's Name: _____

Employer: _____ Phone_____ Employer: _____ Phone: _____

Birthdate:___/___/___ SS# _____ Birthdate ___/___/___ SS# _____

For divorced parents, indicate custody arrangement: _____

HISTORY AND BACKGROUND

Marital Status: _____How long? _____ Number of previous marriages: Self _____ Spouse _____

Spouse/Partner

Name: _____ Occupation: _____ SSN _____

Number of children: Self: _____ Partner: _____ Legal custody: Yes/No

List children and others living in your household:

Name: _____ Age: _____

_____ Age: _____

_____ Age: _____

Faith:_____ Previous Psychotherapy: Yes/No W/Whom?_____

Physician's Name: _____ Phone: _____

Currently under medical care? Yes/ No Reason: _____

Major Accidents, Illnesses, Injuries and Dates: _____

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Current Medications: _____

Significant family mental health and substance abuse history:_____
_____
_____

Do you authorize release of information to your Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication? Do you further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to your health plan and coordination of care? Yes/ No **Initial here** _____

I authorize my insurance carrier to directly pay my practitioner. Yes/No **Initial here** _____

Circle any of the following that apply to you:

Headaches	Panic attacks	Heart palpitations	Appetite change	Apathy
Trouble sleeping	Sexual difficulties	Fearful or shy	Memory problems	Early a.m. waking
Tension & Anxiety	Drugs & Alcohol	Blackouts	Lack of Joy	Poor self image
Depression	Frequent nightmares	Frequently tired	Trouble concentrating	Poor anger control
Low energy	Obsessions/Compulsions	Irritability	Paranoid ideas	Bingeing/Purging

How much alcohol do you drink? _____Day/ Week

How much alcohol does your Spouse/Partner Drink? _____Day/Week

Drug use history: _____

Have you ever attempted suicide? Yes/No Date(s): _____

Are you currently experiencing suicidal thoughts? Yes/No Explain _____

Past or present thoughts or attempts to harm others? Yes/No Explain_____

Current legal or administrative action pending against you? Yes/No Explain _____

Have you ever been convicted of a Crime? Yes/No Explain_____

Why are you coming to counseling? (Please be specific): _____

_____

When you are under stress, or unhappy, what do you do to feel better:

Shop	Gamble	Exercise	Faith	Alcohol
Creative outlet	Work	Hobbies	Talk w/friends	Sex
Drugs	Eat	Groups	Other? _____	

Who do you turn to for support? _____
_____

What do you hope to accomplish from our time together? _____
_____