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DATE _____

CLIENT(S) NAME(S)

_____ D.O.B. _____ AGE _____

_____ D.O.B. _____ AGE _____

HOME ADDRESS _____ CITY _____ ZIP _____

WORK ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ SOCIAL SEC # _____

E-MAIL _____

NAME OF RESPONSIBLE PARTY IF DIFFERENT FROM CLIENT _____

EMPLOYER _____ D.O.B. _____

RELATIONSHIP TO CLIENT _____ SOCIAL SEC # _____

ADDRESS _____ CITY _____ ZIP _____

CLIENT MARITAL STATUS _____ CLIENT OCCUPATION _____

SPOUSE'S NAME _____ SPOUSE'S OCCUPATION _____

CHILDREN'S NAMES AND AGES _____

RELIGIOUS AFFILIATION _____

CURRENT MEDICAL PROBLEMS _____

MEDICATIONS YOU ARE CURRENTLY TAKING

_____ DOSAGE _____ DATE BEGUN _____

_____ DOSAGE _____ DATE BEGUN _____

_____ DOSAGE _____ DATE BEGUN _____

PRESCRIBING PHYSICIAN _____ PH# _____

PERSONAL PHYSICIAN'S NAME _____ PH# _____

DATE OF LAST EXAM _____

HAVE YOU RECEIVED ANY PREVIOUS COUNSELING OR PSYCHIATRIC
TREATMENT? _____

DATE(S) OF TREATMENT _____

PURPOSE OF TREATMENT _____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? _____

DATE(S) OF HOSPITALIZATION _____

PURPOSE OF HOSPITALIZATION _____

BRIEFLY STATE THE NATURE OF YOUR
PROBLEM(S) _____

SIGNATURE OF CLIENT OR RESPONSIBLE PARTY