LOLITA M. DOMINGUE
MARRIAGE & FAMILY THERAPY

1150 N. Mountain Ave., Suite 203
Upland, CA 91785

Please fill out form as completely as possible Today's Date _____

Personal Information

Client Name _____ Date of Birth _____

Name of Spouse/Partner: _____

For Minor client: Parents' Names: _____

Marital Status ❒ Married/Partnered ❒ Separated ❒ Divorced ❒ Widowed ❒ Single

Home Address: _____

City _____ Zip _____

Home Phone: (_____)_____ Other Phone: (_____)_____

Employer _____

Address _____ City/Zip _____

Phone (____)_____ Ext._____ Occupation _____

May you be contacted at work regarding counseling appointment? Yes ❒ No ❒

Child's School Name:_____ City:_____

In case of emergency please notify:

_____ _____

Name Relationship

_____

Address City State Zip

Phone (____)_____ (____)_____

Home Work

Presenting Issue

Who referred you for counseling? _____

_____

Why are you seeking counseling at this time? _____

_____

_____

If symptoms are related to an incident, date incident occurred: _____

_____

Counseling History

Have you ever participated in counseling before? Yes ❒ No ❒

If yes, when and with whom: _____

_____

Do you have any medical condition or are you currently under a doctor's care? Yes ❒ No ❒

If yes, please explain: _____

_____

Doctor's name _____ Phone (____) _____

_____

Address City State Zip

Have you ever been hospitalized? Yes ❒ No ❒

If yes, explain: _____

Are you currently suicidal or have you ever attempted suicide? Yes ❒ No ❒

If yes, explain: _____

_____

Symptoms

Are you currently experiencing any of the following?

Hallucinations	Depression	Panic	Workplace Problems
Suicidal thoughts	Irritability	Racing thoughts	Stomach problems
Paranoid thoughts	Anxiety	Mood swings	Relationship Problems
Homicidal thoughts	Increased eating	Oversleeping	Increased alcohol/drug use
Headaches	Decreased appetite	Insomnia	Financial Problems
Violence	Rages	Crying	Communication Problems
Fighting	Aggression	Withdrawal	Unable to concentrate
School Problems	Non/Compliance	Defiance	Discipline Problems
Arguments	Legal Issues	Other Symptoms: _____	

_____

_____

Please explain any checked symptoms: _____

_____

_____

_____

_____

I request counseling services from Lolita Domingue, MFT and consent to participate in this initial evaluation and screening as indicated by my signature below.

Client Signature	Date
Client Signature	Date
Parent/Guardian Signature	Date
Parent/Guardian Signature	Date
Witness	Date