LOLITA M. DOMINGUE
MARRIAGE & FAMILY THERAPY

1150 N. Mountain Ave. Suite 203
Upland, Ca 91786
909-982-5171

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

Personal Information

Client Name _____ Date of Birth _____
Client Name _____ Date of Birth _____
Client Name _____ Date of Birth _____
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