

**Cal J. Domingue, MFT**Licensed Marriage & Family Therapist
MFC39338

 $3896\ 24^{\text{th}}\ \text{St}$  San Francisco, CA 94114 (415) 377-0544 cal@caltherapy.org

## **Client Information:**

Child's name:				
	First		Middle	
Age:Date of Birth:			Male	Female
Parent/Legal Guardian:				
Address:	Pł	nones: hom	ıe	
		WOI	·k	
Email:		cel	<u> </u>	
Emergency Contact: Name:		Phone:		
It isOK /Not OK (choose one) to It isOK /Not OK (choose one) to It isOK /Not OK (choose one) to Chief Reason for Seeking Therapy for the content of the c	contact me leave messa	via email ages for me	e at the numbe	
Recent History of Presenting Problem (inc	lude attempt	s to address	s this with resul	ts, & successes)
<b>Past History</b> (evaluations, treatment, abuse traumas, hospitalizations, medications, SST resolve, successes):			1	

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**Family Psychiatric History:** Please write in the space provided if any of the child's relatives had each condition. Specify whether the relative was the child's biologic sibling, parent, cousin, uncle, aunt, or grandparent.

	Other (specify)	Mother & her family	Father and his Family
Aggressive or Defiant Childhood behavior			
Short Attention span, hyperactive or impulsive as a child			
Learning Problems (specify)			
Depression, Mania, or suicide attempts			
Chronic or severe anxiety			
Mental retardation or autism			
Tics or rituals			
Drug/ Alcohol abuse (specify)			
Physical or sexual abuse			
Immigration history			
Exposure to trauma			
Other (specify)			



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<b>Developmental History</b> (include colic, difficulty feeding, sleeping, cuddling, age of walking, speaking first words and sentences, bowel and bladder training, coordination, understanding what is said, activit level):
Social History & Support (include living arrangements, supports, stressors, employment, immigration or other legal issues):
<b>Educational History</b> (include grade in school, history of psychoeducational testing, special education, failure or difficulties with handwriting, spelling, reading, math, speech, referrals & results):
<b>Medical History</b> (include chronic or acute illness or physical complaints, immunizations, head injury, loss of consciousness, tics, seizures, snoring, hospitalizations, accidents, medications, allergies):
Your Child's Strengths:
Signature of Parent or Guardian  Date