Bart Catalfio, LMSW, CAADC
Licensed Clinical Social Worker
2345 S. Huron Parkway
Ann Arbor, MI 48104
734-677-4343 (cell)

Client History and Information

Basic Information

Date:

Client Name:

Social Security Number:

Date of Birth:_____ Gender: [ ] Male [ ] Female Ethnicity:_____

Home Address:_____

_____

Home Phone Number: _____May we leave a message? [ ] Yes [ ] No

Work Phone Number: _____May we leave a message? [ ] Yes [ ] No

Mobile Phone Number:_____May we leave a message? [ ] Yes [ ] No

If the above Client is a minor, complete the following:

Name of Guardian:_____

Address of Guardian:_____

Guardian's Home Phone:_____May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone:_____May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone:_____May we leave a message? [ ] Yes [ ] No

If you will be using insurance to cover your sessions or a portion of the cost, please complete the following and allow us to make a photocopy of your insurance card and driver's license (if applicable):

Primary Insurance Company:

Secondary Insurance Company if applicable:

Referral Source

Who referred you to my office, or how did your learn about my practice?_____

_____

In case of an emergency, who should we contact?

Name:_____

Relationship:_____

Address:_____

Phone Number:_____

History Information

Who is providing the history information? [ ] The Client [ ] The Client's guardian [ ] Other

Please describe the current complaint or problem as specifically as you can, in your own words. How long have you experienced this problem, or when did you first notice it? What stressors may have contributed to the current complaint or problem?

_____

_____

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence

[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)

[ ] Depression/Sad/Down feelings

[ ] High/Low energy level

[ ] Angry/Irritable

[ ] Loss of interest in activities

[ ] Difficulty enjoying things

[ ] Crying spells

[ ] Decreased motivation

[ ] Withdrawing from people/Isolation

[ ] Mood Swings

[ ] Black and white thinking/All or nothing

[ ] Negative thinking

[ ] Change in weight or appetite

[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans/Thoughts of hurting yourself

[ ] Self-harm/Cutting/Burning yourself

[ ] Homicidal thoughts or plans/Thoughts of hurting others

[ ] Poor concentration/Difficulty focusing

[ ] Feelings of hopelessness/Worthlessness

[ ] Feelings of shame or guilt

[ ] Feelings of inadequacy/Low self-esteem

[ ] Anxious/Nervous/Tense feelings

[ ] Panic attacks

[ ] Racing or scrambled thoughts

[ ] Bad or unwanted thoughts

[ ] Flashbacks/Nightmares

[ ] Muscle tensions, aches, etc.

[ ] Hearing voices/Seeing things not there

[ ] Thoughts of running away

[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you

[ ] Feelings of frustration

[ ] Feelings of being cheated

[ ] Perfectionism

[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc/Overly concerned about germs

[ ] Distorted body image (believe you are heavier or less attractive than others say you are)

[ ] Concerns about dieting

[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging

[ ] Rules about eating/Compensating for eating

[ ] Excessive exercise

[ ] Indecisiveness about career

[ ] Job problems

[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

What did you like/dislike about previous treatment? What did you learn about yourself through previous counseling/treatment that may help you? Is there any type of treatment you would like to continue?

_____

_____

_____

_____

Have you had hospital stays for psychological concerns? [ ] Yes [ ] No

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? [ ] Yes [ ] No

If yes, explain:_____

Did you walk, talk, and read on time? [ ] Yes [ ] No

Explain:_____

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times?_____

Are you satisfied at where you are in your life? ? [ ] Yes [ ] No

If not, where would you like to be?_____

Medical History

List any current or important past medications

Medication & Dose:	Response to Medication:

History of serious childhood illnesses:_____

_____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:_____

_____

Have you experienced any head injuries? [ ] Yes [ ] No If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No

Explain any allergies you have:_____

_____

How would you rate your current physical health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health "check up?"_____

Do you have a primary care physician? [ ] Yes [ ] No

If yes, complete the following:

Name_____

Address_____

Phone Number_____

Family History

Birth Location:_____

Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father [ ] Other:_____

Relationship with parent figures: (good, fair, poor, close, distant, etc.)

Mother's Name:

Father's Name:

Step-parent's Name(s):

Other:

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?_____

_____

Any family history of substance abuse, mental illness, suicide, or violence?_____

_____

Any Additional Family Information:_____

_____

_____

Social History

Describe your relationship with peers and/or friends?_____

_____

How would you describe your social support network?_____

_____

Describe your hobbies/interests:_____

_____

Describe any cultural concerns:_____

_____

Educational History

When attending school where you:

[ ] In regular classes [ ] Home Study [ ] Special classes [ ] Advanced classes

[ ] Ever suspended [ ] Placed in alternative school

What is the highest educational level you have completed?_____

Give any additional important educational information (i.e. did you like school? Have a learning disability?)

_____

_____

Occupational History

What is your current employment status?

[ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed

[ ] Self-employed [ ] Student [ ] Other

Are you satisfied with your employment? If not, why?_____

_____

Marital History

Which best describes your marital status?

[ ] Married, Date: _____ [ ] Never Married [ ] Widowed, Date: _____

[ ] Separated, Date: _____ [ ] Divorced, Date:_____

If you are married, please briefly describe nature of your marital relationship:_____

_____

_____

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)
[ ] Yes [ ] No

If you answered yes, please complete the following substance abuse history chart.

Describe substance use/abuse history:

Substance	Amount	Frequency	Age @ First Use Date Last Use

Previous treatment for Substance Abuse:

Outpatient where/when)_____

Inpatient (where/when)_____

Cigarette Use? No_____ Yes/Amount_____

Caffeine Use? No_____ Yes/Amount_____

Over the counter drugs_____

Legal History

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Are you on probation? [ ] Yes [ ] No

Name of Probation Officer and County

Have you ever been arrested/convicted of a crime? [ ] Yes [ ] No: If yes,

List any Arrests/Convictions:_____

Date of Arrests/Convictions:_____

Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)

Additional Information

Summarize your goals for counseling/therapy:_____

_____

_____

_____

What expectations do you have for counseling/therapy?_____

_____

_____

_____

Name 5 things you would like to change about yourself:_____

_____

_____

What are your strengths? _____

_____

What are your weaknesses?_____

_____

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

_____

_____

_____

_____

_____ _____

Signature of client or guardian Date