MICHELLE CATANIA, LMFT LLC

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South Windsor, CT
06082

Client Information

Date: _____

Name: _____

Age: _____ **Birth Date:**_____

Address:_____

_____

Phone:_____ **Cell:** _____

May a message be left at this number Y____ N____

Email: _____

Do you want appointment reminders? Yes No

Others Living with you:

Name: Age: Relationship:

_____

_____

_____

Primary Care Physician: _____

Current Medications:

Any History of Hospitalizations, surgeries, or serious illness?

_____

_____

Please Describe previous therapy experiences:

_____

_____

Any history of the following?

Substance abuse:_____

Depression:_____

Suicidal thoughts/gestures/or attempts:

_____

Domestic Violence:_____

Sleeping Problems:_____

Eating Issues:_____

Weight Changes:_____

What do you hope to achieve through therapy?_____

_____

_____

Parent Information (if client is a minor)

Mother's Name and age:_____

Employer:_____

Phone:_____ **Cell?** **yes** **no**

Marital Status:_____

Father's Name and age:_____

Employer:_____

Phone:_____ **Cell?** **yes** **no**

Marital Status:_____

If Parent's are divorced or separated:

Age of child when separation and divorce occurred:_____

Legal/Physical Custody of child:_____

Visitation arrangements: _____

_____