



## Wellness Counseling

*Main Office*

One Heritage Place, Suite 261  
Southgate, Michigan, 48195

32290 Five Mile Road, Suite 1  
Livonia, Michigan, 48154

**(734) 778-0663** Fax (734) 785-8328

### Child History Form

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name and Relationship of Adult completing this form.

\_\_\_\_\_

#### **Present Status**

Behavioral Excesses: What does your child currently do too often, too much, or at the wrong times that get's him/her in trouble?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **Behavioral Deficits**

What does your child fail to do as often as you would like, as much as you would like, or when you would like?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **Behavioral Assets**

What does your child do that you like? What does he/she do that other people like?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **Other Concerns**

Do you have any other concerns about your child or family that you have not mentioned yet?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treatment Goals: What would you like to see your child change about their behavior?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Symptoms**

Is your child experiencing any of the following? (select all that apply)

- Depression
- Mood Swings
- Anxiety
- Attention and Focus
- Loss of a Loved One
- Legal Issues
- Self-Harm
- Relationship Issues
- Sleep Changes
- Loneliness
- Crying Spells
- Medication Changes
- School Problems
- Other

---

---

---

Please describe any past counseling for the child.

---

---

---

**Family History**

Mother's Name, Occupation and Age. Do they live in the home? Describe their relationship with the child.

---

---

Father's Name, Occupation and Age. Do they live in the home? Describe their relationship with the child.

---

---

Sibling(s) Name(s), and Age(s). Describe their relationship with the child. Are they living in the home?

---

---

Other family members/ persons living in the home Name(s) and Age(s). Describe their relationship with the child.

---

---

Who has legal guardianship of the child?

---

---

---

Who supports this child?

---

---

---

If the child lives separate from a biological parent, is there visitation? If yes, what is the visitation schedule?

---

---

---

**Living Arrangements**

How many residences has the child lived in since birth? What cities?

---

---

---

Does this child share a room with anyone else? If Yes, with whom?

---

---

---

**Developmental History**

Was this child planned, unplanned, or adopted?

---

If adopted, what age?

---

Were there any complications during delivery? If yes, please describe.

---

---

Did the child experience late developmental milestones? If yes, please describe.

---

---

Is there a history of head banging, self-harm, problems sleeping, or temper tantrums? If yes, please describe.

---

---

Did the child's mother smoke tobacco, use alcohol, drugs, or any type of medications during pregnancy? If yes, please describe.

---

---

Did the child's mother have any problems during the pregnancy? If yes, please describe.

---

---

**Education History**

What is the name, address, and phone number of your child's school? What is their current grade level?

---

---

What kind of grades do they currently receive?

---

What does your child's teacher say about him/her?

---

---

Has your child ever repeated a grade? If yes, please explain.

---

---

Has the child ever been suspended or expelled? If yes, please explain.

---

---

Has your child ever received special education services? If yes, what are the services?

---

---

Has your child experienced any of the following problems at school? (Please select all that apply)

- Fighting
- Suspension
- Gang Influence
- Lack of or Difficulty Making Friends
- Learning Disabilities
- Incomplete Homework
- Drugs/Alcohol
- Poor Grades
- Poor Attendance
- Behavior Problems
- Detention

**Medical History**

What is the name, address, and phone number of your child's Primary Care Physician?  
Date of the child's last medical examination?

---

---

Please list any other medical conditions including allergies.

---

---

Please list any medications your child takes on a regular basis.

---

---

Please describe any Alcohol/ Drug history including age of first use, preference, quantity, and frequency.

---

---

Previous mental health treatment / Psychiatric Hospitalizations? If so, facility name, month/date, length of stay, and reason for admission

---

---

Please check if your child has had any of the following:

- A Serious Accident
- A Head Injury
- Meningitis
- Hospitalization
- High Fever
- Hearing Problems
- Surgery
- Convulsions/ Seizures
- Allergies
- Asthma
- Eye/ear problems
- Loss of Consciousness

**Other History**

Has the child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe.

---

---

Has the child made statements of wanting to hurt themselves or seriously hurt someone else? If yes, please describe.

---

---

Has the child ever purposely hurt themselves or another person? If yes, please describe the situation.

---

---

Has the child ever experienced any serious emotional losses (such as death / physical separation from a parent, caretaker, sibling, or other loved one)? If yes, please describe.

---

---

Has there ever been any type of legal issues with the child? If so, please explain.

---

---

Has there been any history of Child Protective Services (CPS) involvement? If yes, please explain.

---

---

What are some of the things that are currently stressful to you and your family?

---

---

Anything else you would like your therapist to know?

---

---

---

---