4851 CR 135 McMillan, MI 49853
(906) 235-6750 Phone (844) 241-2634 Fax
trilliumwoodcounselingservices@gmail.com

Child Bio/Psy/Social History Questionnaire

Note: If not the client, please complete as the client would. If there are sections you do not know, please document "NA" in the space.

Full Name: _____ Date: _____ / _____ / _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Social Security number:___-__-____ Insurance Provider & Number_____

Biological Father's Name:_____

Biological Mother's Name:_____

Guardian/Step Parents Name(s):_____

Who do you live with now?_____

Does minor have any children/ages: _____

Address: _____

Phone #: _____ May I leave a message? _____ Yes _____ No

Cell #: _____ May I leave a message? _____ Yes _____ No
May I leave a Text message?____ Yes___No

Social Media Preferred:_____ May I leave a text message? ___ Yes __No
E-mail: _____ May I email you? _____ Yes _____ No

Referred by:_____ Phone#_____

Other Agency(s) Involved:_____ Worker/Phone#_____

Are you employed? _____ Yes _____ No If yes, how many hour per week do you work? _____

Is your current job enjoyable? _____ Yes _____ No Is your job stressful? _____ Yes _____ No

Are you spiritual/religious? _____ Yes _____ No If yes, describe your faith or beliefs?

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How did you hear about Trilliumwood Counseling Services?

Health Information

Rate your physical health? _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very good

Primary Care Physician:_____

List any specific health problems you are currently experiencing: _____

_____

Do you currently take prescription medication? _____ Yes _____ No If yes, please list: _____

_____

How often do you exercise: _____ Type of exercise you participate in: _____

Do you have chronic pain? _____ Yes _____ No If yes, describe _____

Have you had significant life change? _____ Yes _____ No If yes, describe _____

Stressful event? _____ Yes _____ No If yes, describe _____

Traumatic event? _____ Yes _____ No If yes, describe _____

Do you drink alcohol more than once a week? _____ Yes _____ No

Do you engage in recreational drug use? _____ Yes _____ No

Are you in a romantic relationship? _____ Yes _____ No If yes, for how long? _____

On a scale of 1 - 10 (with10 being amazing), how would you rate your relationship? _____

Over the last 2 weeks how often have the following bothered you:	Not At all	Several days	More than half	Most Every day

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Little Interest/pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling/staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you have let yourself or family down	0	1	2	3
Trouble concentrating on things like reading or watching television	0	1	2	3
Moving/speaking so slowly or being so fidgety/restless that other people notice	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	
	Somewhat difficult	
	Very difficult	
	Extremely difficult	

Have you received mental health services before? _____ Yes _____ No If yes, list previous therapists/ practitioners:

Were you ever prescribed psychiatric medication(s)? _____ Yes _____ No If yes, please list:

Family History

Who in your family do you feel closest to and how so?

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When did you leave your family?

Why did you leave?

Any trauma from your childhood (Emotional/Physical)?

How did you deal with these events?

History of family medical problems?

Any family history of mental illness? (list relation and type of mental illness)

Any family substance abuse illness? (list relation and type of mental illness)

Relationship History

Do you get along well with other people?

Any changes in relationships lately? If so, please explain.

If you have children what is your custody arrangement with your children?

Do you consider yourself a good parent? Please explain why or why not.

List any other individuals that live in the home or are important in your life.

Legal History

Are you involved with PROBATION?__
If so, please describe:

Probation Officer:

Are the services you are currently seeking with Trilliumwood court ordered?_____ If yes, by whom?

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Are you experiencing any of the following symptoms:

Anger__
Anxiety__
Compulsive actions__
Dreams__
Depression__
Eating Problems__
Fantasies of Violence__
Fatigue__
Feelings easily hurt/Frequent Crying__
Hallucinations__
Gambling issues__
Financial worries__
Homicidal Thoughts__
Loss of Hope__
Loneliness__
Mood swings__
Nervousness__
Obsessive Thoughts__
Problems with partner/family/children/friends/work__
Sexual Problems__
Panic attacks__
Paranoia__
Racing Thoughts__
Shyness__
Suicidal Thoughts__
Trouble sleeping__
Trouble concentrating__
Irritability__
Weight loss/Gain__
Lack of Confidence__

What are some of your strengths?

What do you consider some of your weakness?

What would you like to accomplish during your time in therapy?

Anything else your psychotherapist at Trilliumwood should know about you?

Signature _____ Date _____

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Please bring completed form to your first session. Information provided here is protected confidential information.