McDOWELL HEALING
ARTS CENTER

McDowell Healing Arts Center, LLC

3323Shattuck Rd, Suite 1Saginaw MI, 48603
2387 S. Linden Rd., Suite 138, Flint, MI 48532
3722 South Straits Highway, Suite B, Indian River, MI 49749
OFFICE (989) 475-4171 FAX (989) 393-6021

Child – Welcome Packet

It brings me immense pleasure to introduce to you ***McDowell Healing Arts Center, LLC, also referred to as MHAC (Pronounced MACK)***. I would like to welcome you to our family of committed and well-trained Therapist and Counselors. While we understand that you could have chosen any other place to fulfill your Mental or Behavioral Health needs, we count it as a privilege to partner with you.

We have included the **Medical Social History & Assessment form -Minor** for your completion for your child. This form is very important to the assessment process. If you arrive for your appointment without this form completed it may result in an interruption to your allotted appointment time or your appointment may need to be rescheduled. You may also download this form from our website at www.mhacenter.com.

Appointment times typically last 45 to 60 minutes. The first portion of your initial appointment is completing additional consent forms. Please remember to bring your child's insurance card(s) with you as well as the attached completed **Child Medical Social History & Assessment Form**. Once your paper work is completed, your therapist will see you.

Please arrive on time to the appointment because there are releases that must be signed prior to you being able to see your therapist.

If you arrive late your appointment may have to be cancelled. It's your responsibility to call and reschedule ASAP. We are an extremely busy practice with limited time slots, so we ask that as soon as you know that you have to cancel or reschedule, please let us know.

If you are unable to keep this appointment, contact the office at (989) 475-4171 asap.

Thank you,

Office Staff

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MEDICAL AND SOCIAL HISTORY AND ASSESSMENT – MINOR (17 & under)

**Please complete the following information. This information is essential to make an accurate assessment of your child's current needs. Complete as much of this assessment as possible and write N/A if something doesn't apply. **

CHILD'S FULL NAME: _____ Date: _____

Birthdate: ___/___/___ Age: ___ Present school_____ Grade_____
Present address: _____City_____
Child lives with: _____

FAMILY MEMBERS (PARENTS):
Please check: ☐ Married ☐ Separated ☐Divorced ☐Re-Married ☐Never Married

Mothers name_____ Birthdate: _____
Present address: _____ City: _____
Cell Phone: _____ Home Phone (If applicable): _____
Employer: _____ Present Health: _____
Present Marriage: Date _____ To whom? _____
Highest Grade Completed: _____

Fathers name_____ Birthdate: _____
Present address: _____ City: _____
Cell Phone: _____ Home Phone (If applicable): _____
Employer: _____ Present Health: _____
Present Marriage: Date _____ To whom? _____
Highest Grade Completed: _____

Resident parent(s):
Please check: ☐Step parent ☐Grandparent ☐Relative ☐Guardian ☐Foster ☐Adoptive ☐Live in partner ☐Other___
Fathers name_____ Birthdate: _____
Present address: _____ City: _____
Cell Phone: _____ Home Phone (If applicable): _____
Employer: _____ Present Health: _____
Present Marriage: Date _____ To whom? _____
Highest Grade Completed: _____

Brothers and Sisters:

Childs brothers or sisters name	"X" If out Of home	Birthdate	Type of relationship (close, distant, conflicted)
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____

Childs Name_____ **Birthdate:** _____

DEVELOPMENTAL HISTORY

PREGNANCY AND BIRTH: ☐Planned ☐ Unplanned ☐Full term ☐premature ☐post mature
Delivery: ☐easy ☐difficult to please☐instruments used ☐natural ☐C section
Was there drug or alcohol use during the pregnancy? ☐no ☐yes Type: _____
Did the mother smoke during the pregnancy? ☐no ☐yes
If there were difficulties with pregnancy or delivery
Describe:_____
_____
_____

INFANT: BIRTH TO ONE YEAR:
Infant:
☐no difficulties
☐cranky ☐difficult to please ☐sleep problems ☐colicky ☐restless ☐fearful ☐cried often ☐inactive ☐rocking
☐irritable ☐active ☐head banging ☐difficulties with eating ☐allergies ☐seizures ☐exposed to neglect or abuse
☐problems with parental drug or alcohol use-type: _____
☐speech, hearing or language problems: _____
Please describe any problems with your child as an infant:
_____
_____

TODDLER: ONE TO THREE YEARS:
Walked alone at age: _____Words at age: _____Sentences at age: _____
Toilet training: Started at age: _____ mastered at age_____ Difficult: ☐yes ☐no
Nightmares or fears: ☐never ☐seldom ☐often. eating problems? ☐No ☐Yes
☐Exposed to possible lead poisoning/lived in home built before 1950?
☐speech, hearing or language problems: _____
☐allergies ☐seizures ☐Exposed to neglect or abuse Type: _____
☐Problems with parental drug or alcohol use-type: _____
☐Problems with parental drug or alcohol use-Type: _____
Please describe your child's
behavior:_____
_____

PRESCHOOL YEARS: THREE TO FIVE YEARS:
☐no difficulties
☐sleep problems ☐night wetting ☐eating difficulties ☐thumb sucking ☐rocking ☐temper tantrums
☐fears ☐night mares ☐shy ☐clumsy ☐aggressive ☐allergies ☐seizures
☐exposed to neglect or abuse type: _____
☐problems with parental drug or abuse type: _____
☐exposed to possible lead poisoning /live in home built before 1950?
☐Speech hearing or language problems: _____
Child attended preschool? _____ Age started? _____
Difficulties with preschool? _____
Describe your child's behavior
_____
_____

Child's Name: _____ Birthdate: _____

CHILDHOOD: SIX TO TWELVE:

Relationship with Parents: ☐ Cooperative ☐ Conflicted ☐ Oppositional ☐ Isolated
Relationship with Siblings: ☐ Cooperative ☐ Conflicted ☐ Oppositional ☐ Isolated
Relationship with Peers (Friends): ☐ Cooperative ☐ Conflicted ☐ None ☐ Many ☐ Few

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☐ Allergies ☐ Seizures ☐ Exposed to Neglect or Abuse Type: _____
☐ Problems with parental drug or alcohol use Type: _____
☐ Youth used alcohol or drugs Type: _____
Impact of use: _____
☐ Speech, hearing, or language problems: _____
School Performance: ☐ Above expected level ☐ At expected level ☐ Below expected level
School Difficulties: _____
_____
Did the school evaluate your child? _____
Was the child on medication? _____ If so, what? _____
Describe your child's behavior: _____
_____
_____
_____

ADOLESCENCE: THIRTEEN TO EIGHTEEN YEARS OLD:

Relationship with Parents: ☐ Cooperative ☐ Conflicted ☐ Oppositional ☐ Isolated
Relationship with Siblings: ☐ Cooperative ☐ Conflicted ☐ Oppositional ☐ Isolated
Relationship with Peers (Friends): ☐ Cooperative ☐ Conflicted ☐ None ☐ Many ☐ Few
Relationship with Authorities: ☐ Cooperative ☐ Conflicted ☐ Oppositional ☐ Isolated

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☐ Allergies ☐ Seizures ☐ Exposed to Neglect or Abuse Type: _____
☐ Problems with parental drug or alcohol use Type: _____
☐ Drug/Alcohol use: ____ Never ____ Occasionally ____ Weekends ____ Daily ____ Unknown
Impact of use: _____
Did the school evaluate your child? _____
Was the child on medication? _____ If so, what? _____

Special Education: ___ No ___ Yes: Type: _____ Started When? _____
☐ Speech, hearing, or language problems: _____
School Performance: ☐ Above expected level ☐ At expected level ☐ Below expected level
School Difficulties: _____
_____
Sexually Active: _____ No _____ Yes _____ Unknown _____ On birth control pills
Are you concerned about risks related to your child's present sexual behavior? ____ No ____ Yes
Suicidal ideas/behavior? ☐ Past Problem ☐ Present Issue
Suicidal issues: ___ Ideas ____ Talk ____ Threats _____ Attempts _____ Medical Attention Resulted
Work Experiences: _____
Involvement with Court? ____ No _____ Yes: When: _____
Charges: _____
Currently on Probation? ____ No _____ Yes: Probation officer: _____
Describe your child's behavior In general: _____
_____
_____
_____

Child's Name: _____ Birthdate: _____

HEALTH & TREATMENT HISTORY

*Please advise your therapist of any infectious condition that your child may have. * - ***Kept Confidential***

Youth's Physician: _____Date Last Seen: _____

Health History: (If experienced, please indicate the child's age next to the condition.)

Allergies:	Eye Problems:	Measles:
Arthritis:	High Blood Pressure:	Migraines:
Asthma:	Fainting Spells:	Paralysis:
Bowel Problems:	Food Sensitivity:	Pneumonia:
Chicken Pox:	Diabetes:	Rheumatic Fever:
Convulsions:	Hay Fever:	Hernia:
Delirium:	Heart Problems:	Hearing Problems:
Depression:	Back Problems:	Tonsillitis:
Ear Infections:	Hemophilia:	Tubes in Ears:
Eating Problems:	High Fevers:	Weight Problems:
Eczema:	Hives:	Whooping Cough:
Epilepsy	Mumps:	Tuberculosis:
HIV:	Sleep Problems:	Other
Cancer:	Seizures:	Over Eating:
Headaches:	Thyroid Problems:	Smoking:
Hepatitis:	Diarrhea:	Rectal Bleeding:
Breathing Problems:	Drinking more than 2 drinks/day:	Head Injury:
Use of Inhalants:	STD/STI:	Birth Control:

Please describe any other health or nutritional information not mentioned in the above conditions: _____

_____

Immunizations: ☐ Child has received all immunizations ☐ Immunizations still needed

Type Needed: _____

Accidents: Type & Age: _____

Operations: Type & Age: _____

Other Hospitalizations: Type & Age: _____

Current Medications:

Medication	Dosage/Time/Day	Date Started	Dr. Prescribing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling: ☐ NO ☐ Yes If yes…

Where: _____ When: _____

Where: _____ When: _____

Medications used: _____Med Helpful: ☐ No ☐ Yes ☐ Neutral

Outcome of Counseling: ☐ Problem Solved ☐ Some Change ☐ No Change ☐ Problem Worse

What was helpful: _____

What was not helpful: _____

Choice for Therapist: ☐ Male ☐ Female ☐ First Available Or: Name: _____

Child's Name: _____ Birthdate: _____

SIGNIFICANT FAMILY EVENTS

Has your family experienced any of the following in the last two years? (please check)

Acute illness: _____ Move of residence: _____ Unemployment: _____
Chronic illness: _____ Re-Marriage: _____ Separation/divorce: _____
Death: _____ Disasters: _____ Violence: _____
Substance abuse: _____ Suicide/attempts: _____ Marital discord: _____
Employment changes: _____ Legal problems: _____ Criminal problems: _____
Accidents: _____ Sexual assault: _____ Other: _____
Prison: _____ Substance abuse: _____

Please describe any other events that may continue to the present problem: _____
_____
_____
_____

FAMILY CIRCUMSTANCES

Please apply a ✓ or and ✗ to any of the circumstances that appear to fit your family. This will assist the therapist in better understanding the factors that may affect your child's problems.

Family Circumstances	Not a problem	A little problem	Moderate	Quite A Bit	Extreme
Marital Conflict					
Disagreement regarding child rearing approaches					
Substance abuse by parent					
Divorce/Separation					
Poverty – Financial Challenges					
Single Parent Family					
Poor housing/neighborhood					
History of violence in the family					
Poor communication in the family					
Parent absent/not involved with the youth					
Parent in jail or prison					
Unemployment					
Grandparent raising the youth					
Legal issues					
Parent feels depressed and overwhelmed					
Parent feels powerless to influence youth					
Lack of support from partner or family members					
No present medical care					

Child's Name: _____ Birthdate: _____

PROBLEM/SYMPTOM CHECKLIST

Below is a list of problems or symptoms. Place x in the box that best applies to the problem or symptom that is listed.

Problems/symptoms	Not a problem	A little problem	Moderate	Quite A Bit	Extreme
Defiant at home, not following home rules					
Frequent arguing at home, conflict with family members					
Controlling temper, outburst of anger					
Fire setting					
Hurting animals					
Defiant at school, not following school rules, authority					
Avoiding school, attendance problems, truancy					
Poor academic performance, not completing assigned work					
Attention problems at school					
Hyperactivity, impulsivity					
Fighting a school, conflicts with peers, classmates					
Depression, feeling of hopelessness					
Apathy, lack of interest in things					
Not sleeping loss of appetite					
Seldom communicates with parents or adults					
Suicidal feelings talk or behavior					
Tendency to withdraw and keep to self and self-isolate					
Low self-esteem, feels bad about self, little confidence					
Reaction to marital separation or divorce					
Sexual assault of others					
Conduct problems-theft, assault, lying, destroying property					
Violence or threat of violence toward others					
Bedwetting or soiling behavior (over age 4)					
Frequent physical symptoms or complaints					
Reaction to death or other loss, grief reaction					
Victim of physical or sexual abuse					
Not eating properly, eating disorders, anorexia, or bulimia					
Reaction to traumatic events, post-traumatic stress					
Excessive worrying, anxiety or panic attacks					
Drug or alcohol problems					
Hearing voices, seeing things, unreal thoughts or beliefs					
Mood swings, unstable moods					
Unsafe sexual activity, poor judgment, promiscuity					

Child's Name: _____ Birthdate: _____

Your present concerns about your child: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

When did these concerns begin? _____

_____

_____

_____

_____

_____

Completed by: _____ Date: _____

Name Relationship

Reviewed by: _____ Date: _____

Therapist