Cruz Clinic
Child & Adolescent Psychosocial Questionnaire
(Ages 1-17)

In order to better serve you, Cruz Clinic would like you to **FULLY** complete this questionnaire and return it to the receptionist as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Date: _______________

Client Name: ____SSN ____ - ____ - ____
Last First MI

Child's D.O.B:______________________________ Age: ________

Parent/Guardian Name: ____SSN _____-_____-_____
Last First MI

Telephone: (________) _________________________ ( ) Home - Ok to leave a message Yes / No

Telephone: (________) _________________________ ( ) Cell - Ok to leave a message Yes / No

Telephone: (________) _________________________ ( ) Work - Ok to leave a message Yes / No

Telephone: (________) _________________________ ( ) Other - Ok to leave a message Yes / No
Please explain "Other" Phone: ____

Primary Care Physician: __________________________________Phone: ________________________
Why have you decided to come into treatment now?
____
____
____

Did anyone refer you to Cruz Clinic?
____
____

What would you like to accomplish by coming to the Cruz Clinic?
____
____
____

Risk Assessment & Protective Factors:

Please indicate whether this child is experiencing any of the following:
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none
( ) physical violence
Please explain:
____
____

Please indicate whether this child has a history of any of the following:
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none
( ) physical violence
Please explain:
____

In the past month did your child:

1	Think that they would be better off dead or wish they were dead?	No	Yes
2	Want to harm himself/herself?	No	Yes
3	Think about suicide?	No	Yes
4	Have a suicide plan?	No	Yes
5	Attempt suicide?	No	Yes
6	Ever make a suicide attempt?	No	Yes

If your child had any thoughts of hurting themselves, what factors would prevent them from action upons these thoughts? Please check all that apply:

____Their religion ____ their family ____ their pet ____ the people they are close to ____ their friends

____belief that things will get better ____belief that suicide is wrong

Your child has friends/family they can talk to: ___ Yes ___ No

Name three things that are very important to your child (such as friends, family, spirituality, pets)

1.____
2.____
3.____

Do you believe your child has conflict resolution skills and non-violent dispute resolution skills?

___Yes ___No

In Case of Emergency, Contact:

Name:______________________________________Relationship:
Address: ____
Home Phone:
Work Phone:

Residence Situation:

( ) lives with both parents ( ) joint custody arrangement ( ) lives with mother
( ) lives with father ( ) lives with grandparents ( ) other

Custody issues we should be aware of: ____
____
____

Family Composition: (number of siblings, parents)

Has a court made any custody decisions for this child?
( ) Yes ( ) No

If yes, Please explain, and please be aware that Cruz Clinic requires a copy of the court papers:
____
____

If any sibling or parent is deceased indicate name and age of death
____

Primary Language ____________________________

Religion ( ) Catholic ( ) Christian or Protestant Christian ( ) Jewish ( ) Muslim ( ) Hindu
( ) Buddhist ( ) Atheist ( ) Agnostic Other:_____________

How important are your Religious/Spiritual Beliefs:
( ) very important ( ) somewhat important ( ) not important

Would you like to talk to your therapist about your religious/spiritual beliefs? Yes / No

Race/Ethnicity ( ) Caucasian ( ) African-American ( ) Native American ( )
Hispanic/Latino ( ) Asian-American ( ) Multiracial ( ) Other:_______________________

Place of Birth ________________________

Sexual Orientation
Does your child identify as ( ) Heterosexual ( ) Lesbian ( ) Gay ( ) Bisexual ( ) Questioning

Gender Orientation
Does your child identify as ( ) Male ( ) Female ( ) Transgender ( ) Self Identify ____________

Would you like to talk to your therapist about any racial, cultural, and sexual identity matters? Yes / No

Behavioral Health Treatment History:
Has your child ever seen a behavioral health care provider before? Yes / No

If yes inpatient or outpatient?
If yes for Inpatient, Name of Facility:
Address:____
Length of Stay:_______________ Number of admissions:

If yes for Outpatient, Name of Facility:
Address:
Name of Therapist:
What type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker
( ) Other: ___________

When did your child see therapist and for what reason:
____
____

Current General Health Status:

Please describe your child's current general health:
( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor

Please explain any health conditions/concerns: ____
____
____

Is your child feeling any physical pain at this time? Yes / No
If yes please explain:

Nutritional Screening:

Has your child **gained weight** or **lost weight** in the last 30-60 days? Yes / No
If yes, how much and why?

Do you have any diet or nutritional concerns about your child? Yes / No
If yes, please explain:

Does your child have any food allergies? Yes / No
If yes, please list:
____
____

Medical:

Do you feel your child needs a physical exam? Yes / No

When was the last time your child had a physical exam?
____

If it has been more than 12 months since your child's previous physical exam, he/she will need to see a primary care doctor.

If it has been more than 12 months since my child's last visit:
( ) I will schedule an appointment with my pediatrician/primary care doctor.
( ) I would like to be referred to a pediatrician/primary care doctor.
( ) I refuse to see a pediatrician/primary care doctor.

Has your child suffered from any **childhood illnesses/disorders, disabilities/handicaps, operations**, and/or **hospitalizations** (please include dates and ages)

___ No
If yes, please explain:

Head Injuries: ( ) None
( ) without loss of consciousness
( ) with loss of consciousness

Please

explain:____
____

Convulsions: ( ) None ( ) without fever ( ) with fever
Please explain:
____
____

Does your child have difficulty sleeping? ( ) Yes ( ) No If yes, Please explain:
____
____

Has your child been exposed to any communicable diseases in the last 3 months?
If yes, please explain: ____

Allergies to Medications:

_____ None

Medication_______________________Type of Allergic Reaction:_______________________________

Medication _______________________Type of Allergic Reaction: _______________________________

Medication_______________________Type of Allergic Reaction:_______________________________

If you have additional allergies, please check here (_____) and continue on reverse

What medications do you know your child should not take? _______________________________________
____

What medications do you know your child should not discontinue to use? __________________________
____

What herbal remedy is your child currently taking? ____
____

Medication History:

Please list all medications your child is **currently** on or have taken in the **last year** (prescription and over-the-counter):

Name of Medication	Dosage	How taken	when started?	Why is child taking?	Dr. who prescribed.

Who has been prescribing the medications listed?
Name:
Address: ____
Telephone No.:____

Substance Use:

Does your child use Nicotine? Yes / No
If yes,
( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco
Amount per day: __________ How long have they used? ______________________
Any related health problems? ____

Does your child use Alcohol? Yes / No
If yes,
How often do they use? ___________ How long have they used? _________________
How much do they usually drink? _____________________
Any related health issues? ______________
If any Recovery, Longest length of Sobriety: ________________

Does your child use any Illegal Drugs? Yes / No
If yes, what drug (s) do they use? ____________________________
How often do they use? ____________________________________ How much do they use?___________
When was the last time they used? ____________

Developmental History:

Duration of Pregnancy: ____

Smoking during pregnancy Yes / No
If yes, number of cigarettes daily: _____________

Alcohol during pregnancy Yes / No
If yes, amount and type:
____

Drugs during pregnancy Yes / No
If yes, please explain:

Medications during pregnancy Yes / No
If yes, please explain:

Complications during pregnancy? Yes / No
What type? ____

Delivery

Was the labor and delivery of your child normal? Yes / No
If No, Please explain:
____
____
Birth Weight______lbs.
Infant days in the Hospital: _______________

APGAR (if known) ______________________

Milestones:

Please indicate and describe if you child has had any problems with **motor skills**, **language**, or **social attachment**: If yes, please specify which area and what happened:

____
____
____
____

Abuse:

Has your child ever experienced any?
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect
If yes, by whom: ____
Length/Duration of abuse:
____
Age of child:
Was it reported to the authorities: Yes / No
Please explain:
____
____

Has your child ever physically, emotionally, or sexually abused anyone? If yes, please explain
____

Has your child ever witnessed abuse?
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse

Has your child ever inflicted abuse on another person?
Physical abuse: Yes / No
Sexual abuse: Yes / No
Emotional abuse: Yes / No

Family Social History:

Name of child's mother: ___________________________________ Age of mother: ____________
Level of Education: ____

Name of child's father: ____________________________________ Age of father:
Level of Education: ____

Biological parents are: ( ) married ( ) separated ( ) divorced ( ) other:___________________

Are both parents aware that child is coming to Cruz Clinic?
( ) Yes ( ) No, If no, please explain:
____
____
How would you describe the relationship between your child and his/her siblings?
( ) Excellent ( ) Good ( ) Fair ( ) Poor
Please explain:
____

Family History:

Please indicate **any family history** of the following:
( ) Substance Abuse: If yes, indicate who: ______________________________
( ) Mental Illness: If yes, indicate who: ______________________________
( ) Suicide: If yes, indicate who: ______________________________
( ) Autism: If yes, indicate who: ______________________________
( ) Developmental Disability, if yes who: ______________________________
( ) ADHD: if yes, who: ______________________________

Social History:

Please indicate if you have the following concerns regarding your child:
( ) Peer Relationships
( ) Gang Involvement
( ) Relationship with Authority
( ) Social Support Networks
( ) Hobbies/Interest

Please list your child's hobbies and leisure activities:
____
____

What are the main strengths of your child?
____
____

What are your child's main weaknesses?
____
____

Education:

What grade is your child currently in?

Child Attended:
( ) Infant day care ( ) pre-school ( ) kindergarten

Official School Classifications
( ) LD or ADHD ( ) ED ( ) MR
( ) Visually Impaired ( ) Hearing Impaired ( ) Other

Type of Placement:
( ) regular classes ( ) special education ( ) honors (T&G) ( ) home study

Please indicate if you have any concerns in the following areas:
( ) Adjustments
( ) Behavioral Problems
( ) Repeated grades
( ) Suspensions/Expulsions
( ) Performance/Achievements
( ) Attitude towards school

Name of School:
Address:
Telephone No.:______________________________
Principal's Name: ______________________________
School Social Worker: ______________________________

I have reviewed and addressed all issues cited on this form with the client and/or guardian.

Signature of Therapist Date

My therapist has reviewed and addressed all my concerns cited on this form with me.

Signature of Parent/Guardian Date

N:forms/Child & Adolescent Psychosocial Questionnaire

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