Cruz Clinic

Adult Client Psychosocial Questionnaire / 2017

(Ages 18+)

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

(if applicable) Guardian Name:_____
Last First MI

Date of Birth:_____Age:_____ Male ____ Female ____ Other Gender Identification _____

Place of Birth:_____ Primary language:_____

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?

_____

_____

_____

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

_____

_____

Who referred you to Cruz Clinic? _____

Criteria for discharge: _____

_____

_____

In Case of Emergency, Contact:

Name:_____Relationship:_____

Address:_____

Home Phone:_____

Work Phone:_____

Client Name:_____

DOB:_____

Suicide Risk Assessment & Protective Factors

Please indicate whether you are experiencing any of the following:
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none ( ) physical violence
Please explain:_____
_____

Please indicate whether you have a **history** of any of the following:
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none
( ) physical violence
Please explain:_____

In the past month did you

1	Think that you would be better off dead or wish you were dead? --	No	Yes
2	Want to harm yourself? -	No	Yes
3	Think about suicide? -	No	Yes
4	Have a suicide plan? -	No	Yes
5	Attempt Suicide? -	No	Yes
6	In your lifetime did you ever make a suicide attempt? - - -	No	Yes

If you have had any thoughts of hurting yourself, what factors would prevent you acting upon those thoughts? Please check all that apply:

____ People that are close to me or rely upon me ____My religion ____My job ____My pets

____ Believe that things can and will get better ____I believe that suicide is wrong

Do you have family /friends that you can talk to: ( ) YES ( ) NO

Name three things that are very important to you (such as family, friends, career, spirituality…)
1._____
2. _____
3. _____

Do you have problem solving, conflict resolution, and/or non-violent dispute resolution skills?
( ) YES ( ) NO

Employment Status:

( ) employed ( ) employed/student ( ) student ( ) unemployed ( ) retired
Your Employer's Name_____

What are your means of support?
( ) self-employed ( )full/part time work ( )parents ( )unemployment ( )spouse ( )other_____
( ) I would like to discuss employment issues with my clinician

Client Name:_____
DOB:_____

Education:

Please indicate your current standing:
( ) did not graduate High School ( ) high School Diploma ( ) GED ( ) some college
( ) associates/bachelors degree ( ) master's degree ( ) doctorate degree
Did you have any behavioral or learning issues? ( ) YES ( )NO If YES, please explain:
_____
_____

Residence Situation:

( ) lives with parents ( ) lives with significant other ( ) lives with spouse ( ) lives alone
( ) other_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Partner

Family Social History:

Name of your mother: _____ Age of mother: _____
If deceased, age at death _____ Level of Education: _____

Name of your father: _____ Age of father:_____
If deceased, age at death _____ Level of Education: _____

Biological parents are: ( ) Married ( ) Separated ( ) Divorced ( ) Other: _____

How would you describe your relationships with your family/siblings?
( ) Excellent ( ) Good ( ) Fair ( ) Poor
Please explain:
_____

Family Composition (number of siblings, parents, children, etc.)
_____
_____
_____
If any siblings are deceased, indicate name and their age at death
_____

How would you describe your relationships with your family/siblings?
Mother ( ) good ( ) fair ( ) poor issue? _____
Father ( ) good ( ) fair ( ) poor issue? _____
Step-Parent ( ) good ( ) fair ( )poor issue? _____
Spouse ( ) good ( ) fair ( ) poor issue? _____
Sig. other ( ) good ( ) fair ( ) poor issue? _____
Child ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Other ( ) good ( ) fair ( ) poor issue? _____

Client Name:_____
DOB:_____

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:_____
( ) Abuse: if yes, who: _____

Social History:

Please indicate if you have any concerns regarding:
( ) Peer Relationships ( ) Marital/Significant other ( ) Social Support Networks
( ) Hobbies/Interest ( ) Relationships with your children ( ) Custody issues
( ) Sexual Issues ( ) Money ( ) Job ( ) Other:_____
If any concerns please explain:_____

Religion: ( ) None OR fill in: _____
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 ( ) Caucasian ( ) African-American ( ) Native American ( ) Asian-American
( ) Other:_____

Ethnicity ( ) Hispanic ( ) Asian ( ) Other_____
Would you like to talk to your therapist about any racial/cultural matters? ( ) YES ( ) NO

Sexual Orientation (optional): ( ) Heterosexual ( ) Lesbian ( ) Gay ( ) Questioning
( ) Other: _____ ( ) Self Identify: _____

Gender Identity (optional): ( ) Male ( ) Female ( ) Transgender
( ) Self identification: _____
Would you like to talk to your therapist about gender or sexual orientation identity? ( ) YES ( ) NO

Behavioral Health Treatment History:

Have you 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:_____

Client Name:_____
DOB:_____

What type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker ( ) Counselor ( ) Other:_____
When did you see the therapist and for what reason:
_____
_____

Current General Health Status:

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

Please check all of the following physical conditions that apply to you now, or in the past.

___Thyroid Problems	_____ Diabetes	_____ Seizures
___Attention Problems	_____ Mental Problems	_____ High Blood Pressure
___Ulcers	_____ Low Blood Sugar	_____ Trouble sleeping
___Colitis	_____ Other	

Please describe: _____
_____
_____
_____

Have you been exposed to any communicable diseases in the past 3 months? ( )YES ( )NO
If YES, please explain:_____

Pain Status: Are you feeling any physical pain at this time? ( ) YES ( ) NO
Please explain: _____
Make a circle around the intensity level of your pain: None 1 2 3 4 5 6 7 8 9 10 Extreme

Medical:

Do you feel like you need a physical exam? ( ) YES ( ) NO
When was the last time you had a physical exam? _____
If it has been more than 12 months since your last physical exam, you will need to see a primary care doctor.

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

Have you suffered from any recent or childhood illnesses/disorders, operations, and/or hospitalizations?
( ) YES ( ) NO If YES please explain and include dates and ages: _____
_____
_____
Have you had any serious accidents/injuries? ( ) YES ( ) NO, If YES, please explain
_____
_____

Head Injuries: ( ) without loss of consciousness ( ) with loss of consciousness
Please explain: _____

Client Name:_____
DOB:_____

Convulsions: ( ) YES ( ) NO, If YES… ( ) without fever ( ) with fever
Please explain: _____
_____
Any Disabilities/Handicaps: ( ) YES ( ) NO if YES, please explain _____
_____

Do out have any **non-food** allergies? ( ) YES ( ) NO
If YES please list allergies and allergic responses: _____
_____

Nutritional Screening:

Have you ( ) gained weight or ( ) lost weight in the last 30-60 days? ( ) YES ( ) NO
If YES, how much and why? _____
_____
_____

Do you believe you have a: ( ) low nutritional risk ( ) medium nutritional risk ( ) high nutritional risk

Do you have any diet or nutritional concerns? ( ) YES ( ) NO
If YES, please explain:_____
_____
_____

Do you have any **food** allergies? ( ) YES ( ) NO
If YES, please list which food and allergic response: _____
_____

Allergies to Medications:

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.

Medications:

Do you currently take any medications: ( ) YES ( ) NO If YES, please list all the medications you are **currently** taking or have taken in the **last year** (prescription and over-the-counter):

Name of Medication	**Dosage**	**How taken**	**When started?**	**Why are you taking?**	**Prescribing doctor**

(If you are taking additional medications, please check here _____ and continue on reverse)

Client Name:_____
DOB:_____

Who has been prescribing the medications listed above?
Name:_____
Address: _____
Telephone: _____

What medications do you know you must continue to take? _____

What supplements are you currently taking?

Name of Supplement	**How often?**	**When started?**	**Why taking supplement?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If you take additional supplements, please check here _____ and continue on reverse)

Substance Use:

Do you use Nicotine? ( ) YES ( ) NO
If yes, ( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco ( ) e-cigarettes
Amount per day: _____ How long have you used? _____
Any related health problems? ( ) YES ( ) NO if YES, please explain_____
_____
Do you use Alcohol? ( ) YES ( ) NO, if YES….
How often do you use? _____ How long have you used? _____
How much do you usually drink? _____

Any related health issues? ( ) YES ( ) NO if YES, please explain: _____
_____
If any Recovery, Longest length of sobriety: _____

Do you use any Illegal Drugs? ( ) YES ( ) NO If YES, what drug (s) do you use? _____
_____

How often do you use? _____ How much do you use?_____
When was the last time you used? _____

Abuse:

Have you ever experienced?
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect ( ) NONE
If yes, by whom: _____
Length/Duration of abuse: _____

Was it reported to the authorities: ( ) YES ( ) NO Please explain: _____
_____
Have you ever physically, emotionally or sexually abused another? ( ) YES ( ) NO, if YES, please explain: _____

Was it reported to the authorities: ( ) YES ( ) NO Please explain:_____

Client Name:_____
DOB:_____

Strengths / Weaknesses:
What do you think are your main strengths and abilities? _____
_____
What do you think are your main weaknesses? _____
_____

Leisure Time
How do you spend your leisure time?
( ) Alone ( ) Mostly Alone ( ) With others ( ) About equal, ½ alone, ½ with others

List your hobbies, leisure interests, activities, interests, talents, etc. _____
_____

Finances:
Do you currently have financial problems? ( ) YES ( ) NO If YES, please explain: _____
_____
_____

Legal History:
Are currently facing any pending charges or convictions? ( ) YES ( ) NO If YES, please explain:
_____
Have you ever been arrested or spent time in prison? ( ) YES ( ) NO If YES, please explain:
_____
Do you currently have a probation officer? ( ) YES ( ) NO If YES…
Name of probation officer:_____Phone Number: _____

Military History:
Were you ever in the following organizations?
( ) Army ( ) Navy ( ) Air force ( ) Marines ( ) Coast Guard ( ) Merchant Marines ( ) None
Duty Status: _____ Discharge Type:_____ Highest Rank:_____

I have completed these questions to the best of my knowledge and I am aware that I can discuss any concerns with my clinician.

_____ _____

Client Name:_____
DOB:_____

Signature of Client/Guardian Date

(For the clinician only) I have reviewed and addressed all issues cited on this form with the client and/or guardian.

_____ _____

Signature of Therapist Date

Client Name:_____
DOB:_____