Cruz Clinic

Integrative Psychology of Ann Arbor

Adult Client Psychosocial Questionnaire / 2020

(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? (c*riteria for discharge*)

_____

_____

_____

Did anyone refer you to Cruz Clinic? ( ) YES ( ) NO If YES, please tell us who referred you:

_____

_____

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
Name of spouse/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?

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? _____

Family History:

Please indicate any family history of the following:
( ) Substance Abuse: indicate who: _____
( ) Mental Illness: indicate who: _____
( ) Suicide: indicate who: _____
( ) Autism: indicate who: _____
( ) Developmental Disability: indicate who: _____

Client Name:_____
DOB:_____

Family History – continued:

( ) ADD/ADHD: indicate who: _____
( ) Abuse: indicate 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: _____

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. _____
_____
_____

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:_____
Type of therapist? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker ( ) Counselor
( ) Other: _____

Client Name:_____
DOB:_____

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 current health status:

_____

_____

_____

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

If YES, please explain: _____

Make a **circle** around the intensity level of pain: **Mild** 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: ( ) NO ( ) YES, without loss of consciousness ( ) YES, with loss of consciousness

Please explain: _____

Convulsions: ( ) YES ( ) NO, If YES… ( ) without fever ( ) with fever

Please explain: _____

_____

Client Name:_____

DOB:_____

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: _____
_____

Dental Screening:

Do you have any dental concerns? (cavities, broken teeth, etc.) ( ) YES ( ) NO

If yes, please explain: _____

Nutritional Screening:

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

Height _____ Weight _____

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

Do you have any diet or nutritional concerns that may be an indication of an eating problem such as binging, inducing vomiting, extreme dieting, etc.: ( ) 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: ( ) 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.

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)

Who has been prescribing the medications listed above?

Client Name:_____
DOB:_____

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: _____

Strengths / Weaknesses:

What do you think are your main strengths and abilities? _____
_____
What do you think are your main weaknesses? _____

Client Name:_____
DOB:_____

____

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.

___________________________________ ________________________________
Signature of Client/Guardian Date

- -
- -

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

___________________________________ ______________________
Signature of Clinician Date
MD/PA/Therapist/NP

Client Name:___________________________________
DOB:____________________