Cruz Clinic
Integrative Psychology of Ann Arbor

Child & Adolescent Psychosocial Questionnaire
(Ages 1-17)

Cruz Clinic and Integrative Psychology are dedicated to providing the best mental health services to all our clients. Please take a moment to carefully complete **ALL** parts of this form. Per state and federal guidelines, Cruz Clinic will always maintain your confidentiality and will not share your information with anyone outside of the practice.

Today's Date: _____/_____/_____ Child's DOB: _____/_____/_____ Age: _____

Child's Legal Name: _____
Last First MI

Name the child would like the clinic to use: _____

Child's Pronouns: [ ] She/her/hers [ ] They/them [ ] He/him/his [ ] Other: _____

Place of Birth: _____ Primary language: _____

PARENT AND CONTACT INFORMATION

Parent/Guardian Name: _____ SSN: ____/____/____
Last First MI

TYPE	PHONE NUMBER	LEAVE A MESSAGE	WHOSE PHONE
Home	( ) -	YES/NO	
Cell	( ) -	YES/NO	
Work	( ) -	YES/NO	
Other	( ) -	YES/NO	

EMERGENCY CONTACT

Name: _____ Relationship to child: _____
Address: _____ Phone: _____-_____-_____

REFERRAL REASON

What brings you and your child to treatment?

_____
_____

What would you/your child like to accomplish by coming to therapy?

_____
_____

Did anyone refer you to our office? [ ] YES [ ] NO
If YES, who? _____

RISK ASSESSMENT & PROTECTIVE FACTORS

Is your child **CURRENTLY** experiencing any of the following symptoms?		
[ ] Suicidal thoughts	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

Has your child **EVER** experienced any of the following symptoms?		
[ ] Suicidal thoughts	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

Parents/guardians, please complete 1 to 5:			
In the past 3 months did your child…			
1	Think they would be better off dead or wish they were dead?	NO	YES
2	Want to harm themselves?	NO	YES
3	Think about suicide?	NO	YES
4	Have a suicide plan?	NO	YES
5	Ever make a suicide attempt?	NO	YES
Child/Adolescent please complete 6 to 13:			
6	I feel happy with my family	NO	YES
7	I feel happy in school	NO	YES
8	Sometimes I feel like crying	NO	YES
9	I have friends	NO	YES
10	I am sleeping well	NO	YES
11	I have some problems/concerns/worries	NO	YES
12	I feel nobody loves/likes me	NO	YES
13	My family would be happier if I didn't live there	NO	YES

If your child had any thoughts of hurting themselves, what factors would prevent them from acting on these thoughts? Please check all that apply: **[ ] None**			
[ ] Religion	[ ] Family	[ ] Pet(s)	[ ] Friends
[ ] Belief that things will get better	[ ] Belief that suicide is wrong	[ ] Other:	

Name three things that are very important to your child (such as friends, family, spirituality, pets)
1.
2.
3.

Client Name: _____
DOB: _____

Do you believe your child has conflict resolution/problem solving skills and non-violent dispute resolution skills?	
YES	NO

FAMILY HISTORY

Child lives with…

[ ] Both Parents [ ] Parent #1 only [ ] Parent #2 only [ ] Grandparents [ ] Legal guardian [ ] Other:_____

Parents are: [ ] Married [ ] Partnered [ ] Separated [ ] Divorced [ ] Other: _____
If deceased, age at death: _____

If parents are divorced, is there a custody agreement? [ ] YES **(please provide copy of legal agreement)** [ ] NO
If YES, briefly describe the agreement:

_____
_____

Has the court made any custody decision for your child? [ ] YES [ ] NO
If YES, please explain? _____

Parent Information

Name of parent #1: _____ Gender: _____ Level of Education: _____
Age of parent #1: _____ If deceased, age at death: _____

Name of parent #2: _____ Gender: _____ Level of Education: _____
Age of parent #2: _____ If deceased, age at death: _____

Are both parents aware that the child is coming to therapy? [ ] YES [ ] NO
If NO, please explain:

_____
_____

Family Composition

Family Member	Name	Relationship Type	Issues *(if any)*
Parent #1		[ ] Good [ ] Fair [ ] Poor	
Parent #2		[ ] Good [ ] Fair [ ] Poor	
Step-Parent #1		[ ] Good [ ] Fair [ ] Poor	
Step-Parent #2		[ ] Good [ ] Fair [ ] Poor	
Sibling #1		[ ] Good [ ] Fair [ ] Poor	
Sibling #2		[ ] Good [ ] Fair [ ] Poor	
Sibling #3		[ ] Good [ ] Fair [ ] Poor	
Other		[ ] Good [ ] Fair [ ] Poor	

Are any of the child's siblings deceased? [ ] YES [ ] NO
If YES, who? _____

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: _____
[ ] ADD/ADHD; indicate 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/Interests [ ] Relationship with your other children [ ] Custody [ ] School
[ ] Other: _____

Leisure Time

How does your child spend their leisure time?

[ ] Alone [ ] Mostly Alone [ ] With Others [ ] About Equal, ½ alone, ½ with Others

Please list your child's hobbies and leisure interests, activities, and talents:

_____
_____

Employment

Please indicate your child's employment status (check all that apply):

[ ] Part-time Employed [ ] Unemployed

Employer: _____ Job Title: _____
Do they have more than one job? [ ] YES, how many: _____ [ ] NO

DEMOGRAPHIC INFORMATION

Religion

[ ] Catholic [ ] Christian [ ] Muslim [ ] Protestant [ ] Mormon [ ] Jewish [ ] Atheist [ ] Agnostic
[ ] Spiritual but not religious [ ] No affiliation [ ] Not listed: _____
How **important** is your child's religious/spiritual beliefs? [ ] Very [ ] Somewhat [ ] Not
Would you like your child like to talk about their religious/spiritual beliefs with their therapist? [ ] YES [ ] NO

Race/Ethnicity

[ ] Black/AA [ ] White [ ] Native American or Alaska Native [ ] Asian [ ] Native Hawaiian or other Pacific Islander [ ] Mixed [ ] Not listed: _____
Is your child Hispanic? [ ] YES [ ] NO
Would you like your child like to talk about any racial/cultural issues? [ ] YES [ ] NO

Sexual Orientation

[ ] Heterosexual [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Pansexual [ ] Asexual [ ] Queer
[ ] Questioning [ ] Not listed _____
Would you like your child like to talk about their sexual orientation with their therapist? [ ] YES [ ] NO

Gender Identity

[ ] Female [ ] Male [ ] Transgender [ ] Gender non-conforming/non-binary [ ] Not listed: _____
Would you like your child like to talk about their gender identity with their therapist? [ ] YES [ ] NO

BEHAVIORAL HEALTH TREATMENT HISTORY

Has your child ever worked with a behavioral health care provider? [ ] YES [ ] NO

[ ] **Inpatient** date: _____
If YES, for inpatient, name of facility: _____
Length of Stay: _____ Number of admissions: _____
Reason: _____

[ ] **Outpatient** date: _____
If YES for outpatient, name of facility: _____
Name of therapist: _____
Type of therapist? [ ] Psychiatrist [ ] Psychologist [ ] Social Worker [ ] Counselor [ ] Other: _____
Reason: _____

CURRENT GENERAL HEALTH STATUS

Please describe your child's current **general** health:
[ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Please indicate all the physical conditions your child is experiencing:			
[ ] Thyroid Problems	[ ] Attention Problems	[ ] Ulcer	[ ] Colitis
[ ] Diabetes	[ ] Mental Health Issues	[ ] Low Blood Sugar	[ ] Seizures
[ ] High Blood Pressure	[ ] Trouble Sleeping	[ ] Vitamin D Deficiency	[ ] Other

Does your child have any other health conditions? [ ] YES [ ] NO
If YES, please explain:_____

Please describe your child's **current** health status:
_____
_____

Has your child been exposed to any communicable diseases in the past 3 months? [ ] YES [ ] NO
If YES, please explain: _____

Primary Care Physician

Name: _____ Office Name: _____
Office Address: _____
Office Phone: _____ Office Fax: _____

Pain Status

Is your child currently experiencing pain? [ ] YES [ ] NO
If YES, please explain: _____
Please indicate the severity of your child's pain: **Mild** 1 2 3 4 5 6 7 8 9 10 **Extreme**

Medical

Does your child need 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, they will need to see a primary care doctor.

If it has been more than 12 months since your 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) [ ] YES [ ] NO
If YES, please explain and include dates and ages:
_____
_____

Has your child had any serious accidents/injuries? [ ] YES [ ] NO
If YES, please explain _____

Head Injuries: [ ] YES, **with** loss of consciousness [ ] YES, **without** loss of consciousness [ ] NO
If YES, please explain: _____

Convulsions: [ ] YES, **with** fever [ ] YES, **without** fever [ ] NO
If YES, please explain: _____

Does your child have any disabilities or special needs that we should be aware of? [ ] YES [ ] NO
If YES, please explain:
_____

Sleep

Does your child have difficulty sleeping? [ ] YES [ ] NO
If YES, please explain:
_____
How long does your child typically sleep? _____ What time do they go to sleep? _____ and wake up? _____
My child's overall quality of sleep is: [ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Dental Screening

Does your child have any dental concerns (cavities, broken teeth, etc.)? [ ] 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? _____
_____

Child's Height: _____ft. _____ins. Child's Weight: _____lbs.

Do you believe your child is at a: [ ] low nutritional risk [ ] medium nutritional risk [ ] high nutritional risk

Does your child 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:_____

Food Allergies

Does your child have any **food** allergies? [ ] YES [ ] NO

If YES please list allergies and allergic reaction:

_____

_____

Non-Food Allergies

Does your child have any **non-food** allergies? [ ] YES [ ] NO

If YES please list allergies and allergic reaction:

_____

_____

Medication Allergies

Does your child have any **medication** allergies? [ ] YES [ ] NO

Medication Name	Reaction

Current Medications

Does your child **currently** take any medications: [ ] YES [ ] NO

If YES, please list all the medications your child is **currently** taking or has taken in the **last year** (prescription and over the counter):

Medication Name	Dosage	How is it taken?	Start Date	Reason	Prescribing Doctor/Location	Works Well (YES/NO)

Past Psychotropic Medications

Has your child taken any psychotropic medications in the past: [ ] YES [ ] NO

If YES, please list all the medications your child has taken in the **last year** (prescription and over the counter):

Medication Name	Dosage	How is it taken?	Start Date	Reason	Prescribing Doctor/Location	Works Well (YES/NO)

If your child takes additional medications, please check here [ ] and continue in space below.

Who has been prescribing the medications listed above?

Name:_____

Address: _____

Phone: _____

Supplements

Supplement Name	Dosage	How is it taken?	Start Date	Reason

SUBSTANCE USE

Does your child use nicotine? [ ] YES [ ] NO

If YES, [ ] Cigarettes/Cigars/Pipe [ ] Chewing tobacco [ ] E-cigarettes [ ] Vape

Amount per day: _____ How long have they used? _____

Any related health issues? [ ] YES [ ] NO If YES, please explain: _____

Does your child consume alcohol? [ ] YES [ ] NO

How often does your child consume? _____ How long have they used? _____

How much does your child usually drink? _____

Does your child have any alcohol related health issues? [ ] YES [ ] NO

If YES, please explain: _____

If any recovery, longest length of sobriety: _____

Does your child use cannabis? [ ] YES [ ] NO

If YES, in what form? _____

How often does your child use? _____ How much does your child use? _____

Does your child use any recreational or mind-altering substances? [ ] YES [ ] NO

If YES, what drug(s) does your child use? _____

How often does your child use? _____ How much does your child use? _____

ABUSE

Has your child ever experienced any of the following? (check all that apply)				
[ ] Physical	[ ] Sexual	[ ] Emotional	[ ] Abandonment/Neglect	[ ] Other
If YES, please explain:				
Duration of abuse:				
Was the abuse reported to the authorities? [ ] YES [ ] NO If yes, please explain:				
Has your child ever physically, emotionally, or sexually abused anyone? [ ] YES [ ] NO				
If YES, please explain:				
Was the abuse reported to the authorities? (please explain)				

Has your child every witnessed any of the following? (please check all that apply) [ ] Physical abuse [ ] Emotional abuse [ ] Sexual abuse [ ] Other:
If YES, please explain:

STRENGTHS/WEAKNESSES

What are your child's main strengths and abilities?

_____

_____

What are your child's main weaknesses?

_____

_____

FINANCES

Does your family currently have financial problems? [ ] YES [ ] NO

If YES, please explain:

_____

_____

LEGAL HISTORY

Is your child currently facing any pending legal charges/convictions? [ ] YES [ ] NO

If YES, please explain: _____

Has your child ever been arrested or spent time in jail? [ ] YES [ ] NO

If YES, please explain: _____

Does your child currently have a probation officer? [ ] YES [ ] NO

If YES, Name of probation officer: _____ Phone Number: _____

DEVELOPMENTAL HISTORY

Pregnancy

Duration of pregnancy:	
Did the birthmother consume any of the following during pregnancy? (check all that apply)	If YES, please explain:
[ ] Smoking [ ] Alcohol [ ] Drugs [ ] Other	

Complications during pregnancy? [ ] YES [ ] NO

If YES, please explain: _____

Delivery

Was the labor and delivery of your child normal? [ ] YES [ ] NO

If NO, please explain:

Birth Weight: _____lbs. _____ oz. Infant days in the Hospital: _____ APGAR (if known): _____

Milestones

Please indicate and describe if your child has had any problems with **motor skills**, **language**, or **social attachment**:

EDUCATION

What grade is your child currently in? _____

Name of School:_____

Address:_____

Telephone No.:_____

Child Attended: [ ] Infant daycare [ ] Pre-school [ ] Kindergarten

Official School Classifications & Learning Disabilities:

[ ] LD [ ] EI [ ] ADHD [ ] ASD [ ] Visually Impaired [ ] Hearing Impaired

[ ] Dyslexia [ ] Other Health Impairments: _____

Type of Educational Placement: [ ] General Education [ ] Special Education [ ] Honors (T&G) [ ] Home study

Please indicate if you have any of the following concerns:			
[ ] Adjustment	[ ] Behavioral	[ ] Repeated grade	[ ] Suspension/Expulsion
[ ] Academic Achievement	[ ] Attitude towards school	[ ] Learning	[ ] Other

DEVELOPMENTAL PERSPECTIVE PARENT/GUARDIAN

	Below age expectation	**At expected age level**	**Above age expectation**
Physical			
Emotional			
Cognitive			
Educational			
Nutritional			
Socialization			

Concerns:

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 Parent/Guardian Date

PARENTS/GUARDIANS STOP HERE

\- -
\- -

This portion for clinician use:

DEVELOPMENTAL PERSPECTIVE OF PROVIDER/PRESCRIBER

Clinician:

	Below age expectation	At expected age level	Above age expectation
Physical			
Emotional			
Cognitive			
Educational			
Nutritional			
Socialization			

Concerns:

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

________________________________ ____________________
Signature of Clinician Date
MD/PA/Therapist/Nurse Practitioner

Client Name: ________________________________
DOB: ________________________