Cruz Clinic
Integrative Psychology of Ann Arbor

Adult Psychosocial Questionnaire
(Ages 18+)

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: _____/_____/_____ DOB: _____/_____/_____ Age: _____

Legal Name: _____ SSN: ____/____/____
Last First MI
Guardian name: _____

Name you want the clinic to use: _____

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

Place of Birth:_____ Primary language:_____

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

Please explain "other" phone- _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ _____
Address: _____ Phone: _____-_____-_____

REFERRAL REASON

What brings you to treatment?
_____
_____

What would you like to accomplish by coming for treatment?
_____
_____

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

RISK ASSESSMENT & PROTECTIVE FACTORS

Are you **CURRENTLY** experiencing any of the following symptoms? **[ ] None**		
[ ] Suicidal thoughts/expression	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

Have you **EVER** experienced any of the following symptoms? **[ ] None**		
[ ] Suicidal thoughts/expression	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

In the past month did you…			
1	Think 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	Attempted suicide?	***NO***	***YES***
6	In your lifetime, did you ever make a suicide attempt?	***NO***	***YES***

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

Do you have family/friends you can talk to? [ ] Yes [ ] No

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

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

Client Name: _____

DOB: _____

EMPLOYMENT & EDUCATION

Employment

Please indicate your employment status (check all that apply)
[ ] Full-time Employed [ ] Part-time Employed [ ] Unemployed [ ] Retired

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

What are your means of support?
[ ] work [ ] parents [ ] unemployment [ ] spouse [ ] other_____
[ ] I would like to discuss employment issues with my clinician

Current Education

Please indicate your current education enrollment
[ ] Full-time Student [ ] Part-time Student [ ] Not Enrolled [ ] Not a Student
Please indicate the type of school you attend
[ ] University [ ] College [ ] Vocational/Trade [ ] Other:_____
Name of school:_____ Degree type/field_____

Education History

Please indicate your highest level of education
[ ] Some High School [ ] High School Diploma [ ] GED [ ] Some College/Trade School
[ ] Associates Degree [ ] Bachelor's Degree [ ] Master's Degree [ ] Doctoral Degree

Did you attend: [ ] Infant day care [ ] Pre-school [ ] Kindergarten

Official School Classifications & Learning Disabilities:
[ ] LD or ADHD [ ] EI [ ] DHI [ ] ASD [ ] Visually Impaired [ ] Hearing Impaired
[ ] Dyslexia [ ] Other:_____

Type of K12 Educational Placement: [ ] General Education [ ] Special Education [ ] Honors (T&G) [ ] Home study

FAMILY HISTORY

Residence

[ ] Live with parents [ ] Live with partner [ ] Live with spouse [ ] Live alone [ ] Other:_____

Martial Status

[ ] Married [ ] Partnered [ ] Separated [ ] Divorced [ ] Widowed [ ] Other:_____
If spouse/partner is deceased, age at death _____

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 _____

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

Primary Parental figures: _____

Family Composition

Family Member	Name	Relationship Type	Issues *(if any)*
Partner/Spouse		[ ] Good [ ] Fair [ ] Poor	
Child #1		[ ] Good [ ] Fair [ ] Poor	
Child #2		[ ] Good [ ] Fair [ ] Poor	
Child #3		[ ] Good [ ] Fair [ ] Poor	
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	

Is your parent, child, or sibling 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:
[ ] Peer Relationships [ ] Sexual Concerns [ ] Marital/Significant Other [ ] Job [ ] Money
[ ] Hobbies/Interest [ ]Relationship with family [ ] Custody [ ] School [ ] Other: _____

Leisure Time

How do you spend your leisure time?
[ ] Alone [ ] Mostly Alone [ ] With others [ ] About equal, ½ alone, ½ with others

Please list hobbies leisure interests, activities, and talents
_____
_____

DEMOGRAPHIC INFORMATION

Religion

[ ] Catholic [ ] Christian [ ] Muslim [ ] Protestant [ ] Mormon [ ] Jewish [ ] Atheist [ ] Agnostic
[ ] Spiritual but not religious [ ] No affiliation [ ] Other: _____
How **important** are your Religious/Spiritual Beliefs? [ ] Very [ ] Somewhat [ ] Not at all
Would you like to talk about their religious/spiritual beliefs? [ ] YES [ ] NO

Race/Ethnicity

[ ] Black/AA [ ] White [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian [ ] Mixed
[ ] Other _____
Are you Hispanic? [ ] YES [ ] NO Would you like to talk about any racial/cultural issues? [ ] YES [ ] NO

Sexual Orientation

[ ] Heterosexual [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Pansexual [ ] Asexual [ ] Queer [ ] Questioning
[ ] Other _____
Would you like to talk about your sexual orientation with your therapist? [ ] YES [ ] NO

Gender Identity

[ ] Female [ ] Male [ ] Transgender [ ] Gender non-conforming/non-binary [ ] Other: _____
Would you like to talk about your gender identity with your therapist? [ ] YES [ ] NO

BEHAVIORAL HEALTH TREATMENT HISTORY

Have you 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 treatment ended: (such as, successful, could not afford, did not like therapist, other)
_____

CURRENT & GENERAL PHYSICAL HEALTH STATUS

Please describe your general health:

[ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

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

Do you have any other health conditions? [ ] YES [ ] NO
If YES, please explain: _____

Have you 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: _____

Reproductive Health

Would you like to speak about reproductive health matters? [ ] YES [ ] NO

Pain Status

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

Medical

Do 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 previous physical exam, you will need to see a primary care doctor.

If it has been more than 12 months since my 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, disabilities/handicaps, 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: [ ] None [ ] Yes, **without** loss of consciousness [ ] Yes, **with** loss of consciousness
Please explain: _____

Convulsions: [ ] YES [ ] with fever [ ] without fever} [ ] NO
Please explain: _____

Do you have any disabilities or special needs that we should be aware of? [ ] YES [ ] NO
if YES, please explain:
_____

Are you able to meet all your activities of daily living? (To care for yourself). [ ] YES [ ] NO
If NO, please explain:
_____

Sleep

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

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? _____

_____

Your Height: _____foot ____inches Your Weight: _____lb

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:_____

Food Allergies

Do you have any **food** allergies? [ ] YES [ ] NO
If YES please list allergies and allergic reaction:

_____

_____

Non-Food Allergies

Do you have any **non-food** allergies? [ ] YES [ ] NO
If YES please list allergies and allergic reaction:

_____

_____

Medication Allergies

Do you have any **medication** allergies? [ ] YES [ ] NO

Medication Name	Reaction

Current 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):

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

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

Past Psychotropic 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):

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

Supplements

Supplement Name	Dosage	How is it taken?	Start Date	Reason

SUBSTANCE USE

Do you use nicotine? [ ] YES [ ] NO

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

Amount per day: _____

How long have you used? _____

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

Do you use cannabis? [ ] YES [ ] NO

If YES, in what form? _____

How often do you use? _____

How much do you use? _____

Do you consume alcohol? [ ] YES [ ] NO

How often do you consume? _____ How long? _____

How much do you usually drink in one sitting?_____

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

If any Recovery, Longest length of sobriety: _____

Do you use illegal drugs? [ ] YES [ ] NO

If YES, please list all illegal drugs you use:_____

_____

How often do you use? _____

How much do you use? _____

Would you like to discuss your substance use with your provider? [ ] YES [ ] NO

Client Name: _____

DOB: _____

ABUSE

Have you ever experienced any of the following? (check all that apply) [ ] YES [ ] NO				
[ ] 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:				
Have you ever physically, emotionally, or sexually abused anyone? [ ] YES [ ] NO If yes, please explain: Was it reported to the authorities? [ ] YES [ ] NO				
Have you ever 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 main strengths and abilities?

_____

_____

What are your main weaknesses?

_____

_____

FINANCES

Do you currently have financial problems? [ ] YES [ ] NO

If YES, please explain:

_____

_____

LEGAL HISTORY

Are you currently facing any pending legal charges/convictions? [ ] YES [ ] NO

If YES, please explain: _____

Have you ever been arrested or spent time in jail? [ ] 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: _____

DEVELOPMENTAL HISTORY

Pregnancy

Duration of pregnancy: _____ months/weeks Length of delivery: _____hours/days [ ] unknown

Substance Use	**Delivery**
Did your birthparent consume any of the following during pregnancy? (check all that apply) [ ] unknown [ ] Smoking [ ]Alcohol [ ] Drugs [ ] Other If yes, please explain:	What type of **delivery** were you? [ ] unknown [ ] Cesarean Section [ ] Vaginal Birth Weight ____lb Any complication during delivery: [ ] YES [ ] NO If yes, please explain:
Complications while Pregnant	**Developmental Milestones**
Any known complications while your birthparent was pregnant with you? [ ] unknown [ ] YES [ ] NO If yes, please explain:	Please indicate and describe if you had any problems with **motor skills, language, or social attachment**. [ ] unknown [ ] YES [ ] NO If yes, please explain:

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 Date

STOP HERE

- -
- -
- -

Client Name: _____

DOB: _____

(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

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