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, we 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 child want 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 (*criteria for discharge*)

_____

_____

Did anyone refer you to Cruz Clinic or Integrative Psychology? [ ] 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 he/she would be better off dead or wish he/she 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	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:			
[ ] Religion	[ ] Family	[ ] Pet(s)	[ ] Friends
[ ] Belief things will get better	[ ] Believe that suicide is wrong	[ ] Other:	

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

FAMILY HISTORY

Child lives with…

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

Parents are: [ ] Married [ ] 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, Who?_____

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/Interest [ ]Relationship with your other children [ ]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

_____
_____

DEMOGRAPHIC INFORMATION

Religion

[ ] Catholic [ ] Christian [ ] Muslim [ ] Protestant [ ]Mormon [ ] Atheist [ ] Agnostic [ ] Jewish
[ ] Spiritual but not religious [ ] No affiliation [ ] Other: _____

How **important** is your child's Religious/Spiritual Beliefs? [ ] Very [ ] Somewhat [ ] Not
Would your child 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 your child like to talk about any racial/cultural issues? [ ] YES [ ] NO

Sexual Orientation (optional)

[ ] Straight [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Pansexual [ ] Asexual [ ] Queer
[ ] Questioning
[ ] Other _____

Gender Identity (optional)

[ ] Female [ ] Male [ ] Transgender [ ] Gender non-conforming/non-binary [ ] Other: _____

Would your child like to talk about their gender Identity? [ ] 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	[ ] Other	

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 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) [ ] 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: [ ]None [ ] Yes, **without** loss of consciousness [ ] Yes, **with** loss of consciousness
Please explain: _____

Convulsions: [ ] YES { [ ] with fever [ ] without fever} [ ] NO
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:
_____

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: _____ Child's Weight: _____lb

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

If YES please list allergies and allergic reaction:

_____

_____

Medications

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

If YES, please list all the medications your child is **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/Clinic

If your child is taking additional medications, please check here [ ] and continue on reverse

Who has been prescribing the medications listed above?

Name:_____

Address: _____

Phone: _____

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

Supplements

Supplement Name	Dosage	How is it taken?	Start Date	Reason

If your child takes additional supplements, please check here [ ] and continue on reverse

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 use? _____ How long has 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: _____

Do your child use cannabis? [ ] YES [ ] NO
If YES, in what form?
How often does your child use? _____
How much does your child use? _____

Do your child use any illegal drugs? [ ] 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 police?: (please explain)				
Has your child ever physically, emotionally, or sexually abused anyone? [ ] YES [ ] NO If yes, please explain: Was it reported? [ ] YES [ ] NO				
Has your child every witnessed any of the following? (please check all that apply) [ ] Physical abuse [ ] Emotional abuse [ ] Sexual abuse [ ] Other:				

STRENGTHS /WEAKNESSES

What are your child's main strengths and abilities?

_____

_____

What are your child's main weaknesses?

_____

_____

FINANCES

Do 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. 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**.

If yes, please explain:

EDUCATION

What grade is your child currently in?_____

Name of School:_____
Address:_____
Telephone No.:_____

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

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

DEVELOPMENTAL PERSPECTIVE PARENT/GUARDIAN

Parents/Guardian Section:

	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

- -

- -

DEVELOPMENTAL PERSPECTIVE OF PROVIDER/PRESCRIBER

This portion for clinician use:

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