

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	
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	WHOSE PHONE
Home	() - - -	YES/NO	
Cell	() - - -	YES/NO	
Work	() - - -	YES/NO	
Other	() - - -	YES/NO	

EMERGENCY CONTACT

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

REFERRAL REASON

What brings you to treatment?

What would you 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

N:\forms\patient forms\Adult Psychosocial Questionnaire 2022 (revised 8-2022)

Client Name: _____
 DOB: _____

Are you CURRENTLY experiencing any of the following symptoms?		
<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Homicidal thoughts	<input type="checkbox"/> Physical violence
If you checked any of the above boxes, please explain:		

Have you EVER experienced any of the following symptoms?		
<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Homicidal thoughts	<input type="checkbox"/> Physical violence
If you checked any of the above boxes, please explain:		

<i>In the past month did you...</i>			
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

If you had any thoughts of hurting yourself, what factors would prevent you from acting on these thoughts? Please check all that apply:			
<input type="checkbox"/> Religion	<input type="checkbox"/> Family	<input type="checkbox"/> Pet(s)	<input type="checkbox"/> Friends
<input type="checkbox"/> Belief things will get better	<input type="checkbox"/> Believe that suicide is wrong	<input type="checkbox"/> Other:	

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 skills and non-violent dispute resolution skills?	
YES	NO

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

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/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: _____

Marital Status

Married Partnered Separated Divorced Widowed Other: _____

If 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 _____

Are you biological parents married/partnered? YES NO

Primary Parental figures: _____

Family Composition

Family Member	Name	Relationship Type	Issues (if any)
Partner/Spouse		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Child #1		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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 partner/spouse, 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 [] Atheist [] Agnostic [] Jewish
 [] 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

Straight Lesbian Gay Bisexual Pansexual Asexual Queer
 Questioning
 Other _____

Would you like to talk about your sexual orientation with your therapist? YES NO

Gender Identity (optional)

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: _____

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			
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Attention Problems	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Colitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Other	

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 (please include dates and ages) 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:

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 bingeing, 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

If YES please list allergies and allergic reaction:

Medications

Do you 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 you are 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 you must continue to take? _____

Supplements

Supplement Name	Dosage	How is it taken?	Start Date	Reason

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 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? _____

ABUSE

Have you ever experienced any of the following? (check all that apply)				
<input type="checkbox"/> Physical	<input type="checkbox"/> Sexual	<input type="checkbox"/> Emotional	<input type="checkbox"/> Abandonment/Neglect	<input type="checkbox"/> Other
If YES, please explain:				
Duration of abuse:				
Was the abuse reported to the police?: (please explain)				
<u>Have you ever</u> physically, emotionally, or sexually abused anyone? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain:				
Was it reported? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Have you ever witnessed any of the following? (please check all that apply)				
<input type="checkbox"/> Physical abuse <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Other:				

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: _____

DEVELOPMENTAL HISTORY

Pregnancy

Duration of pregnancy: _____ months/weeks Length of delivery: _____ hours/days	
<p style="text-align: center;">Substance Use</p> <p>Did your birthparent consume any of the following during pregnancy? (check all that apply)</p> <p>[] Smoking [] Alcohol [] Drugs [] Other</p> <p>If YES, please explain:</p>	<p style="text-align: center;">Delivery</p> <p>What type of delivery were you?</p> <p>[] Cesarean Section [] Vaginal</p> <p>Birth Weight _____lb</p> <p>Any complication during delivery: [] YES [] NO</p> <p>If Yes, please explain:</p>
<p style="text-align: center;">Complications while Pregnant</p> <p>Any known complications while your birthparent was pregnant with you? [] YES [] NO</p> <p>If Yes, please explain:</p>	<p style="text-align: center;">Developmental Milestones</p> <p>Please indicate and describe if you had any problems with motor skills, language, or social attachment.</p> <p style="text-align: right;">[] YES [] NO</p> <p>If yes, please explain:</p>

Signature of Client

Date

STOP HERE

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

Signature of Clinician
MD/PA/Therapist/Nurse Practitioner

Date