

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?		
<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:		

Has your child 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:		

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: <input type="checkbox"/> None			
<input type="checkbox"/> Religion	<input type="checkbox"/> Family	<input type="checkbox"/> Pet(s)	<input type="checkbox"/> Friends
<input type="checkbox"/> Belief that things will get better	<input type="checkbox"/> Belief that suicide is wrong	<input type="checkbox"/> 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/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		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Parent #2		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Step-Parent #1		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Step-Parent #2		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Sibling #1		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Sibling #2		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Sibling #3		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Other		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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:			
<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"/> Vitamin D Deficiency	<input type="checkbox"/> 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 bingeing, inducing vomiting, extreme dieting, etc.? YES NO

If YES, please explain: _____

Food AllergiesDoes your child have any **food** allergies?

[] YES [] NO

If YES please list allergies and allergic reaction:

Non-Food AllergiesDoes your child have any **non-food** allergies?

[] YES [] NO

If YES please list allergies and allergic reaction:

Medication AllergiesDoes your child have any **medication** allergies?

[] YES [] NO

Medication Name	Reaction

Current MedicationsDoes 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 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 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)

- Smoking
 Alcohol
 Drugs
 Other

If YES, please explain:

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:			
<input type="checkbox"/> Adjustment	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Repeated grade	<input type="checkbox"/> Suspension/Expulsion
<input type="checkbox"/> Academic Achievement	<input type="checkbox"/> Attitude towards school	<input type="checkbox"/> Learning	<input type="checkbox"/> Other

DEVELOPMENTAL PERSPECTIVE PARENT/GUARDIAN

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

Concerns:

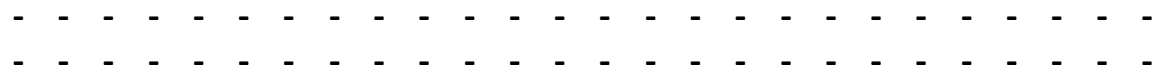
I have completed these questions to the best of my knowledge, and I am aware that I can discuss any concerns with my clinician.

By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

Signature of Parent/Guardian

Date

PARENTS/GUARDIANS STOP HERE



DEVELOPMENTAL PERSPECTIVE OF PROVIDER/PRESCRIBER

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

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