Cruz Clinic

Child & Adolescent Psychosocial Questionnaire / 2018

(Ages 1-17)

In order to better serve you, Cruz Clinic would like you to **FULLY** complete this questionnaire and return it to the receptionist as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Today's Date: _____

Client Name: _____SSN _____ - ____ - _____
Last First MI

Parent/Guardian Name: _____SSN _____-_____-_____
Last First MI

Date of Birth: _____Age: ____ Male ____ Female _____ Other Gender Identification _____

Place of Birth:_____ Primary language:_____

Telephone: (_____) _____ ( ) Home - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Cell - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Work - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Other - OK to leave a message YES / NO

Please explain "Other" Phone: _____

Primary Care Physician: _____Phone: _____

Why have you decided to come into treatment now?

_____
_____
_____

What would you like to accomplish by coming to the Cruz Clinic? (*criteria for discharge*)

_____
_____

Did anyone refer you to Cruz Clinic? ( ) YES ( ) NO If YES, please tell us who referred you:

_____
_____

In Case of Emergency, Contact:

Name:_____Relationship:_____
Address: _____
Home Phone:_____
Work Phone:_____

Risk Assessment & Protective Factors:

Please indicate whether this child is **experiencing** any of the following: ( ) None
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) physical violence
Please explain:

_____
_____

Please indicate whether your child has a **history** of any of the following: ( ) None
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) physical violence
Please explain:
_____
_____

Parents 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) ____ the people they are close to ____ their friends

____belief that things will get better ____belief that suicide is wrong _____ other (please explain)
_____

Does your child has friends/family they can talk to: ( ) YES ( ) NO

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

Residence Situation:

( ) lives with both parents ( ) joint custody arrangement ( ) lives with mother
( ) lives with father ( ) lives with grandparents ( ) other_____

Family Social History:

Name of child's mother: _____Level of Education: _____
Age of Mother: _____If deceased, age at death _____

Name of child's father: _____Level of Education: _____
Age of father _____If deceased, age at death _____

Biological parents are: ( ) married ( ) separated ( ) divorced ( ) other:_____
If deceased, age at death _____

Are both parents aware that child is coming to Cruz Clinic?
( )YES ( ) NO, If NO, please explain:
_____
_____
How would you describe your child's relationships with your family/siblings?
( ) Excellent ( ) Good ( ) Fair ( ) Poor

Family Composition: (number of siblings, parents) - please include names

_____
_____
_____
If any sibling or parent is deceased indicate name and age of death:
_____

How would you describe the relationship between your child and his/her family?
Mother ( ) good ( ) fair ( ) poor issue? _____
Father ( ) good ( ) fair ( ) poor issue? _____
Step-Parent ( ) good ( ) fair ( )poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Other ( ) good ( ) fair ( ) poor issue? _____

Custody issues we should be aware of: _____
_____
_____

Has a court made any custody decisions for this child? ( ) YES ( ) NO
If YES, please explain, and please be aware that Cruz Clinic requires a copy of the court papers:
_____
_____

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: _____
If any concerns, please explain: _____

Leisure Time

How does your child spend his/her leisure time?
( ) Alone ( ) Mostly Alone ( ) with others ( ) About equal, ½ alone, ½ with others

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

Religion ( ) NONE, or fill in: _____
How important is your child's Religious/Spiritual Beliefs:
( ) very important ( ) somewhat important ( ) not important
Would you like to talk to your therapist about your child's religious/spiritual beliefs? ( ) YES ( ) NO

Race ( ) Caucasian ( ) African-American ( ) Native American ( ) Asian-American
( ) Other: _____

Ethnicity ( ) Hispanic ( ) Asian ( ) Other
Would you like to talk to your therapist about any racial/cultural issues? ( ) YES ( ) NO

Sexual Orientation (optional): ( ) Heterosexual ( )Lesbian ( )Gay ( )Questioning
( ) N/A ( ) Other: _____

Gender Identity (optional): ( )Male ( )Female ( )Transgender
( ) Self identification: _____
Would you like to talk to your therapist about gender or sexual orientation identity? ( ) YES ( ) NO

Behavioral Health Treatment History:

Has your child ever seen a behavioral health care provider before? ( ) YES ( ) NO

If YES, inpatient or outpatient? _____
If YES, for Inpatient, Name of Facility:_____
Address:_____
Length of Stay:_____ Number of admissions:_____

If YES for Outpatient, Name of Facility:_____
Address:_____
Name of Therapist:_____
Type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker ( ) Counselor
( ) Other: _____

When did your child see therapist and for what reason?
_____
_____
_____

Current General Health Status:

Please describe your child's current general health:

( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor

Please check all of the following physical conditions that apply to you now, or in the past.

___Thyroid Problems	_____ Diabetes	_____ Seizures
___Attention Problems	_____ Mental Problems	_____ High Blood Pressure
___Ulcers	_____ Low Blood Sugar	_____ Trouble sleeping
___Colitis	_____ Other	

Please describe current health status:

_____
_____
_____
_____

Have you been exposed to any communicable diseases in the past 3 months? ( ) YES ( ) NO
If YES, please explain:_____

Pain Status: Is your child feeling any physical pain at this time? ( ) YES ( ) NO
If YES, please explain: _____
Make a **circle** around the intensity level of your pain: **Mild** 1 2 3 4 5 6 7 8 9 10 **Extreme**

Medical:

Do you feel your child needs 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, he/she 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: _____
_____
_____
_____
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 ( ) NO If YES… ( ) without fever ( ) with fever
Please explain: _____
_____
Any Disabilities/Handicaps: ( ) YES ( ) NO if YES, please explain _____
_____

Do out have any **non-food** allergies? ( ) YES ( ) NO
If YES please list allergies and allergic responses: _____
_____

Does your child have difficulty sleeping? ( ) 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? _____
_____
_____

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? ( ) YES ( ) NO
If YES, please explain:_____
_____
_____

Does your child have any **food** allergies? ( ) YES ( ) NO
If YES, please list which food and allergic response: _____
_____

Allergies to Medications: **( )** NONE

Medication _____ Type of allergic reaction _____

Medication _____ Type of allergic reaction _____

Medication _____ Type of allergic reaction _____

If your child has additional allergies please check here ( ) and continue on reverse.

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):

Name of Medication	**Dosage**	**How taken**	**When started?**	**Why are you taking?**	**Prescribing doctor**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(If your child is taking additional medications, please check here _____ and continue on reverse)

Who has been prescribing the medications listed above?
Name:_____
Address: _____
Telephone: _____

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

What supplements is your child currently taking?

Name of Supplement	**How often?**	**When started?**	**Why taking supplement?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(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
Amount per day: _____ How long have they used? _____
Any related health issues? ( ) YES ( ) NO if YES, please explain: _____
_____

Does your child use Alcohol? ( ) YES ( ) NO, if YES….
How often does your child use? _____ How long has he/she used? _____
How much does your child usually drink?
_____

Any related health issues? ( ) YES ( ) NO if YES, please explain: _____
_____
If any Recovery, Longest length of sobriety: _____

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? _____
When was the last time your child used? _____

Abuse:

Has your child ever experienced any?
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect ( ) NONE
If YES, by whom:
_____
Length/Duration of abuse:
_____

Was abuse reported to the authorities: ( ) YES ( ) NO Please explain:
_____
_____

Has your child ever physically, emotionally, or sexually abused anyone? ( ) YES ( ) NO
If YES, please explain:
_____
_____
_____

Was it reported to the authorities: ( ) YES ( ) NO Please explain:_____

Has your child ever witnessed abuse? ( ) YES ( ) NO If YES, please check off:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse

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 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:

Duration of Pregnancy: _____

Smoking during pregnancy ( ) YES ( ) NO
If YES, number of cigarettes daily: _____

Alcohol during pregnancy ( ) YES ( ) NO
If YES, amount and type:

_____

Drugs during pregnancy ( ) YES ( ) NO
If YES, please explain:_____

_____

_____

Medications during pregnancy ( ) YES ( ) NO
If YES, please explain:_____

_____

_____

Complications during pregnancy? ( ) YES ( ) NO
What type? _____

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 you child has had any problems with **motor skills**, **language**, or **social attachment**: If yes, please specify which area and what happened:

_____
_____
_____
_____

Education:

What grade is your child currently in?_____

Child Attended:
( ) Infant day care ( ) pre-school ( ) kindergarten

Official School Classifications
( ) LD or ADHD ( ) EI ( ) DHI ( ) ASD
( ) Visually Impaired ( ) Hearing Impaired ( ) Other
If other, please explain: _____

Type of Placement:
( ) regular classes ( ) special education ( ) honors (T&G) ( ) home study

Please indicate if you have any concerns in the following areas:
( ) Adjustments
( ) Behavioral Problems
( ) Repeated grades
( ) Suspensions/Expulsions
( ) Performance/Achievements
( ) Attitude towards school
( ) Learning issues

Did your child have any learning issues? ( ) YES ( ) NO If YES, please explain:
_____
_____

Name of School:_____
Address:_____
Telephone No.:_____
Principal's Name: _____
School Social Worker: _____

Developmental Perspective:

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

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Developmental Perspective continued:
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

N:forms/patient forms/Child & Adolescent Psychosocial Questionnaire 2018 (revised 4-2018)

Client Name: ___________________________________
DOB: _________________________