

Client Name: _____

Cruz Clinic
17177 North Laurel Park Dr.
Ste 131
Livonia, Michigan 48152

Child & Adolescent Psychosocial Questionnaire
(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.

Date: _____

Client Name: _____ SSN _____ - _____ - _____
Last First MI

Guardian Name: _____
Last First MI

Child's D.O.B: _____ Age: _____

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?

Please indicate whether this child is experiencing any of the following:

suicidal ideas/expression **homicidal ideas/expression** **none**

Please explain: _____

Please indicate whether this child has a history of any of the following:

suicidal ideas/expression **homicidal ideas/expression** **none**

Please explain: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____

Work Phone: _____

Residence Situation:

lives with both parents joint custody arrangement lives with mother

lives with father lives with grandparents other _____

Family Composition:

Client Name: _____

Religion (Optional) () Catholic () Protestant () Jewish () Hindu () Other

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 (Optional) () Caucasian () African-American () Native American

() Hispanic () Asian-American () Other: _____

Would you like to talk to your therapist about any racial/cultural issues?

Yes / No

Client's 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: _____

What type of therapist were they? () Psychiatrist () Psychologist () Social Worker

() Other: _____

When did your child see therapist and for what reason:

Medication History:

What medication do you know your child should not take? _____

What medication do you know your child should not stop taking? _____

What herbal remedies is your child currently taking? _____

Please list all medications this child is **currently** on or has taken in the **last year** (prescription and over-the-counter):

Who has been prescribing the medications listed above?

Name: _____

Address: _____

Telephone No.: _____

Current General Health Status:

Please describe your child's current general health:

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

Is your child feeling any physical pain at this time? Yes / No

If yes please explain: _____

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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 have any diet or nutritional concerns about your child? Yes / No

If yes, please explain: _____

Does your child have any food or medication allergies? Yes / No

If yes, please list: _____

Substance Use:

Does your child use Nicotine? Yes / No

If yes,

() Cigarettes/Cigars/Pipe () Chewing tobacco

Amount per day: _____ How long have they used? _____

Any related health problems? _____

Does your child use Alcohol? Yes / No

If yes,

How often do they use? _____ How long have they used? _____

How much do they usually drink? _____

Any related health issues? _____

If any Recovery, Longest length of Sobriety: _____

Does your child use any Illegal Drugs? Yes / No

If yes, What drug (s) do they use? _____

How often do they use? _____ How much do they use? _____

When was the last time they used? _____

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

Medical:

Do you feel your child needs a physical exam? Yes / No

When was the last time your child had a physical exam? _____

Has your child suffered from any **childhood illnesses/disorders, operations, and/or hospitalizations** (please include dates and ages)
If yes, please explain:

Head Injuries: () without loss of consciousness
() with loss of consciousness

Please explain: _____

Convulsions: () without fever () with fever

Please explain: _____

Abuse:

Has your child ever experienced any:

- () Physical Abuse () Sexual Abuse
() Emotional Abuse () Abandonment/Neglect

If yes, by whom: _____
Length/Duration of abuse: _____

Age of child: _____
Was it reported to the authorities: Yes / No
Please explain: _____

Has your child ever witnessed abuse:

- () Physical Abuse () Sexual Abuse
() Emotional Abuse

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Has your child ever inflicted abuse on another person:

Physical abuse: Yes / No

Sexual abuse: Yes / No

Emotional abuse: Yes / No

Family Social History:

Name of child's mother: _____ Age of mother: _____

Level of Education: _____

Name of child's father: _____ Age of father: _____

Level of Education: _____

Biological parents are: () married () separated () divorced () other: _____

How would you describe the relationship between your child and his/her siblings?:

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

Please explain: _____

Family History:

Please indicate **any family history** of the following:

() Substance Abuse: If yes, indicate who: _____

() Mental Illness: If yes, indicate who: _____

() Suicide: If yes, indicate who: _____

() Autism: If yes, indicate who: _____

() Developmental Disability, if yes who: _____

() ADHD: if yes, 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

Please list your child's hobbies and leisure activities:

What are the main strengths of your child?

Education:

What grade is your child currently in: _____

Child Attended:

() Infant day care () pre-school () kindergarten

Official School Classifications

() LD or ADHD () ED () MR

() Visually Impaired () Hearing Impaired () Other

Type of Placement:

() regular classes () special education () honors (T&G) () home study

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Please indicate if you have any concerns in the following areas:

- Adjustments
- Behavioral Problems
- Repeated grades
- Suspensions/Expulsions
- Performance/Achievements
- Attitude towards school

Name of School: _____

Address: _____

Telephone No.: _____

Principal's Name: _____

School Social Worker: _____

STOP! VERY IMPORTANT

Please sign this document while you are meeting with your therapist.

I have reviewed and addressed all issues cited on this form with the client and/or guardian.

Signature of Therapist

Date

My therapist has reviewed and addressed all my concerns cited on this form with me.

Signature of Parent/Guardian

Date