



Please explain:

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In the past month did your child:

- |   |  |    |     |
|---|--|----|-----|
| 1 | Think that they would be better off dead or wish they 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 | Attempt suicide?   | No | Yes |
| 6 | Ever make a suicide attempt?                                     | No | Yes |

If your child had any thoughts of hurting themselves, what factors would prevent them from action upon these thoughts? Please check all that apply:

Their religion  their family  their pet  the people they are close to  their friends  
 belief that things will get better  belief that suicide is wrong

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

### 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

Custody issues we should be aware of: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Marital Status

Single  Married

Client Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**Family Composition:** (number of siblings, parents)

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:

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

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**Primary Language** \_\_\_\_\_

**Religion**  Catholic  Protestant  Jewish  Muslim  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**  Caucasian  African-American  Native American  
Asian-American  Other: \_\_\_\_\_

**Ethnicity**  Hispanic  Other

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

Yes / No

Place of birth: \_\_\_\_\_

**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:

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**Client Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_

**Current General Health Status:**

Please describe your child's current general health:

Excellent     Very Good     Good     Fair     Poor     Very Poor

Please explain any health conditions/concerns: \_\_\_\_\_

\_\_\_\_\_

Is your child feeling any physical pain at this time? 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 have any diet or nutritional concerns about your child? Yes / No

If yes, please explain:

Does your child have any food allergies? Yes / No

If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

**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)

\_\_\_ No

If yes, please explain:

Head Injuries:     None without loss of consciousness

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

( ) with loss of consciousness

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Convulsions: ( ) None ( ) without fever ( ) with fever

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Does your child have difficulty sleeping? ( ) Yes ( ) No If yes, Please explain:

\_\_\_\_\_  
\_\_\_\_\_

Has your child been exposed to any communicable diseases in the last 3 months?

If yes, please explain: \_\_\_\_\_

**Allergies to Medications:**

\_\_\_\_ None

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

Medication \_\_\_\_\_ Type of Allergic Reaction: \_\_\_\_\_

If you have additional allergies, please check here (\_\_\_\_) and continue on reverse

What medications do you know your child should not take? \_\_\_\_\_  
\_\_\_\_\_

What medications do you know your child should not discontinue to use? \_\_\_\_\_  
\_\_\_\_\_

What herbal remedy is your child currently taking? \_\_\_\_\_  
\_\_\_\_\_

**Medication History:**

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

Name of Medication Dosage How taken when started? Why is child taking? Dr. who prescribed.

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Client Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

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Who has been prescribing the medications listed?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

### 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

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 physically, emotionally, or sexually abused anyone? If yes, please explain

\_\_\_\_\_

Has your child ever witnessed abuse?

- Physical Abuse                       Sexual Abuse
- Emotional Abuse

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: \_\_\_\_\_

Are both parents aware that child is coming to Cruz Clinic?

Yes  No, If no, please explain:

\_\_\_\_\_

Client Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

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

Excellent     Good     Fair     Poor

Please explain:

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### 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:

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What are the main strengths of your child?

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What are your child's main weaknesses?

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### 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

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

- Adjustments
- Behavioral Problems
- Repeated grades
- Suspensions/Expulsions

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_



- ( ) Performance/Achievements
- ( ) Attitude towards school

Name of School:

Address:

Telephone No.: \_\_\_\_\_

Principal's Name: \_\_\_\_\_

School Social Worker: \_\_\_\_\_

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

N:forms/patient forms/Child & Adolescent Psychosocial Questionnaire 2016

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Client Name: \_\_\_\_\_  
DOB: \_\_\_\_\_