CRUZ CLINIC

CHILDREN'S RISK ASSESSMENT/PROTECTIVE FACTORS

This from is to be completed by the parents based on responses provided **by the child**

Name:_____

◯ Male ◯ Female DOB:_____

1.	I feel happy with my family	YES	NO
2.	I feel happy in my school	YES	NO
3.	Sometimes I feel like crying	YES	NO
4.	I have friends	YES	NO
5.	I am sleeping well	YES	NO
6.	I have some problems/concerns/worries	YES	NO
7.	I like living in my house	YES	NO
8.	I feel nobody loves me/likes me	YES	NO
9.	My family would be happier if I didn't live there	YES	NO
10.	I am afraid of _____		

Things that make me happy: (Please list at least four)

1:_____

2:_____

3:_____

4:_____

_____ _____

Parent's signature Therapist's signature

_____ _____

Date Date