

Cruz Clinic

Child & Adolescent Psychosocial Questionnaire / 2020
(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:

Client Name: _____
DOB: _____

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

Client Name: _____
DOB: _____

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: _____

Client Name: _____
DOB: _____

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, 1/2 alone, 1/2 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?

Client Name: _____
DOB: _____

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> 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: _____

Client Name: _____
DOB: _____

Does your child have difficulty sleeping? () YES () NO If YES, Please explain:

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? _____

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: _____

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: _____

Client Name: _____
DOB: _____

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: _____

Client Name: _____
DOB: _____

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:

Client Name: _____
DOB: _____

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:

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			

Client Name: _____
 DOB: _____

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



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.

Client Name: _____
DOB: _____

Signature of Clinician
MD/PA/Therapist/Nurse Practitioner

Date

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Client Name: _____
DOB: _____