

Cruz Clinic
Integrative Psychology of Ann Arbor

Adult Client Psychosocial Questionnaire / 2020
(Ages 18+)

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

(If applicable) Guardian Name: _____
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: _____

Client Name: _____
DOB: _____

Suicide Risk Assessment & Protective Factors

Please indicate whether you are **experiencing** any of the following:

() suicidal ideas/expression () homicidal ideas/expression () none () physical violence

Please explain: _____

Please indicate whether you have a **history** of any of the following:

() suicidal ideas/expression () homicidal ideas/expression () none

() physical violence

Please explain: _____

In the past month did you

- 1 Think that you would be better off dead or wish you were dead? -- NO YES
- 2 Want to harm yourself? ----- NO YES
- 3 Think about suicide? ----- NO YES
- 4 Have a suicide plan? ----- NO YES
- 5 Attempt Suicide? ----- NO YES
- 6 In your lifetime did you ever make a suicide attempt? --- NO YES

If you have had any thoughts of hurting yourself, what factors would prevent you acting upon those thoughts? Please check all that apply:

___ People that are close to me or rely upon me ___ My religion ___ My job ___ My pets

___ Believe that things can and will get better ___ I believe that suicide is wrong

Do you have family /friends that you can talk to: () YES () NO

Name three things that are very important to you (such as family, friends, career, spirituality...)

- 1. _____
- 2. _____
- 3. _____

Do you have problem solving, conflict resolution, and/or non-violent dispute resolution skills?

() YES () NO

Employment Status:

() employed () employed/student () student () unemployed () retired

Your Employer's Name _____

What are your means of support?

() self-employed () full/part time work () parents () unemployment () spouse () other _____

() I would like to discuss employment issues with my clinician

Client Name: _____

DOB: _____

Education:

Please indicate your current standing:

- did not graduate High School high School Diploma GED some college
- associates/bachelors degree master's degree doctorate degree

Did you have any behavioral or learning issues? YES NO If YES, please explain:

Residence Situation:

- lives with parents lives with significant other lives with spouse lives alone
- other _____

Marital Status: Single Married Divorced Widowed Partner

Name of spouse/partner: _____

Family Social History:

Name of your mother: _____ Age of mother: _____

If deceased, age at death _____ Level of Education: _____

Name of your father: _____ Age of father: _____

If deceased, age at death _____ Level of Education: _____

Biological parents are: Married Separated Divorced Other: _____

How would you describe your relationships with your family/siblings?

- Excellent Good Fair Poor

Please explain: _____

Family Composition (number of siblings, parents, children, etc.)

If any siblings are deceased, indicate name and their age at death

How would you describe your relationships with your family?

- Mother good fair poor issue? _____
- Father good fair poor issue? _____
- Step-Parent good fair poor issue? _____
- Spouse good fair poor issue? _____
- Sig. other good fair poor issue? _____
- Child good fair poor issue? _____
- Sibling good fair poor issue? _____
- Sibling good fair poor issue? _____
- Sibling good fair poor issue? _____
- Other good fair poor issue? _____

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: _____

Client Name: _____

DOB: _____

Family History – continued:

() ADD/ADHD: indicate who: _____
() Abuse: indicate who: _____

Social History:

Please indicate if you have any concerns regarding:

- () Peer Relationships () Marital/Significant other () Social Support Networks
- () Hobbies/Interest () Relationships with your children () Custody issues
- () Sexual Issues () Money () Job () Other: _____

If any concerns please explain: _____

Leisure Time

How do you spend your leisure time?

- () Alone () Mostly Alone () With others () About equal, ½ alone, ½ with others

List your hobbies, leisure interests, activities, interests, talents, etc. _____

Religion: () None OR fill in: _____

How important are your Religious/Spiritual Beliefs:

- () very Important () somewhat important () not important

Would you like to talk to your therapist about your 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 matters? () YES () NO

Sexual Orientation (optional): () Heterosexual () Lesbian () Gay () Questioning

() Other: _____ () Self Identify: _____

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:

Have you 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? () Psychiatrist () Psychologist () Social Worker () Counselor

() Other: _____

Client Name: _____

DOB: _____

When did you see the therapist and for what reason:

Current General Health Status:

Please describe your 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: Are you feeling any physical pain at this time? () YES () NO

If YES, please explain: _____

Make a **circle** around the intensity level of pain: **Mild** 1 2 3 4 5 6 7 8 9 10 **Extreme**

Medical:

Do you feel like you need a physical exam? () YES () NO

When was the last time you had a physical exam? _____

If it has been more than 12 months since your last physical exam, you will need to see a primary care doctor.

If it has been more than 12 months since your last visit:

- () I will schedule an appointment with my primary care doctor.
- () I would like to be referred to a primary care doctor.
- () I refuse to see a primary care doctor.

Have you suffered from any recent or childhood illnesses/disorders, operations, and/or hospitalizations?

() 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: () NO () YES, without loss of consciousness () YES, with loss of consciousness

Please explain: _____

Convulsions: () YES () NO, If YES... () without fever () with fever

Please explain: _____

Client Name: _____
DOB: _____

Any Disabilities/Handicaps: () YES () NO if YES, please explain _____

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

Dental Screening:

Do you have any dental concerns? (cavities, broken teeth, etc.) () YES () NO

If yes, please explain: _____

Nutritional Screening:

Have you () gained weight or () lost weight in the last 30-60 days? () YES () NO

If YES, how much and why? _____

Height _____ Weight _____

Do you believe you have a: () low nutritional risk () medium nutritional risk () high nutritional risk

Do you have any diet or nutritional concerns that may be an indication of an eating problem such as
binging, inducing vomiting, extreme dieting, etc.: () YES () NO

If YES, please explain: _____

Do you 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 you have additional allergies, please check here () and continue on reverse.

Medications:

Do you currently take any medications: () YES () NO If YES, please list all the medications
you are **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 you are taking additional medications, please check here () and continue on reverse)

Who has been prescribing the medications listed above?

Client Name: _____
DOB: _____

Name: _____
Address: _____
Telephone: _____

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

What supplements are you currently taking?

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

(If you take additional supplements, please check here _____ and continue on reverse)

Substance Use:

Do you use Nicotine? () YES () NO
If YES, () Cigarettes/Cigars/Pipe () Chewing tobacco () e-cigarettes
Amount per day: _____ How long have you used? _____
Any related health problems? () YES () NO if YES, please explain _____

Do you use Alcohol? () YES () NO, if YES....
How often do you use? _____ How long have you used? _____
How much do you usually drink? _____

Any related health issues? () YES () NO if YES, please explain: _____

If any Recovery, Longest length of sobriety: _____

Do you use any Illegal Drugs? () YES () NO If YES, what drug (s) do you use? _____

How often do you use? _____ How much do you use? _____
When was the last time you used? _____

Abuse:

Have you ever experienced?
() Physical Abuse () Sexual Abuse
() Emotional Abuse () Abandonment/Neglect () NONE
If yes, by whom: _____
Length/Duration of abuse: _____

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

Have you ever physically, emotionally or sexually abused another? () YES () NO, if YES, please explain: _____

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

Strengths / Weaknesses:

What do you think are your main strengths and abilities? _____

What do you think are your main weaknesses? _____

Client Name: _____
DOB: _____

Finances:

Do you currently have financial problems? () YES () NO If YES, please explain: _____

Legal History:

Are currently facing any pending charges or convictions? () YES () NO If YES, please explain: _____

Have you ever been arrested or spent time in prison? () YES () NO If YES, please explain: _____

Do you currently have a probation officer? () YES () NO If YES...

Name of probation officer: _____ Phone Number: _____

Military History:

Were you ever in the following organizations?

() Army () Navy () Air force () Marines () Coast Guard () Merchant Marines () None

Duty Status: _____ Discharge Type: _____ Highest Rank: _____

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 Client/Guardian

Date

(For the clinician only)

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

Signature of Clinician
MD/PA/Therapist/NP

Date

Client Name: _____
DOB: _____