

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: \_\_\_\_\_ Male \_\_\_ Female \_\_\_\_\_

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?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who referred you to Cruz Clinic? \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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

**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

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

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

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

\_\_\_\_\_

**Primary Language**

**Religion**    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**    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: \_\_\_\_\_

**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: \_\_\_\_\_

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

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:**

**Allergies to Medications:**

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? \_\_\_\_\_

\_\_\_\_\_

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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who has been prescribing the medications listed above?

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

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

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

**Current General Health Status:**

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

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: \_\_\_\_\_

\_\_\_\_\_

**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:

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

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

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 you 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? \_\_\_\_\_

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)

If yes, please explain:

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

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

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

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

Convulsions: ( ) 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: \_\_\_\_\_

**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: \_\_\_\_\_

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

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

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

**Family History:**

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

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

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.**

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

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 drive :forms/child new pt. rev 10-2011