

# Child and Adolescent Database

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Date: \_\_\_\_\_

**DIRECTIONS:** Your cooperation in answering the questions below will increase the efficiency of my evaluation of your child or adolescent. If you need more space than provided, please continue your answer on the reverse side. Please print or write legibly as this will become part of your child's record. Thank you.

H. William Martin, Jr., M.D.

## I. FAMILY STRUCTURE

A. Name of child/adolescent \_\_\_\_\_

B. Address of child/adolescent \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Date of birth \_\_\_\_\_ Age \_\_\_\_\_

D. School \_\_\_\_\_ Grade \_\_\_\_\_

E. School phone \_\_\_\_\_ Teacher \_\_\_\_\_

F. Sex \_\_\_\_\_ If your child is adopted, check here \_\_\_\_\_

G. Home phone \_\_\_\_\_ Fax \_\_\_\_\_

Work phone (mother) \_\_\_\_\_ Cell (mother) \_\_\_\_\_

Work phone (father) \_\_\_\_\_ Cell (father) \_\_\_\_\_

E-mail Addresses \_\_\_\_\_

H. Please list names and ages of other children in the family. Please state if any of the children are half-siblings or step-siblings.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do any of the other siblings have emotional or behavioral problems? \_\_\_\_\_

How severe is sibling rivalry? \_\_\_\_\_

I. Does anyone else live with the family (grandparents, live-in domestics)?  
\_\_\_\_\_

- J. Father's name \_\_\_\_\_ Age \_\_\_\_\_
- K. Father's address \_\_\_\_\_
- L. Educational background of Father \_\_\_\_\_
- M. Occupation of Father \_\_\_\_\_
- N. Mother's name \_\_\_\_\_ Age \_\_\_\_\_
- O. Mother's address \_\_\_\_\_
- P. Educational background of Mother \_\_\_\_\_
- Q. Occupation of Mother \_\_\_\_\_
- R. Step-parent's name \_\_\_\_\_  
 Emotional relationship with step-parent \_\_\_\_\_
- S. Date of marriage of parents \_\_\_\_\_
- T. Have there been previous marriages for either parent? If so, please give any significant details \_\_\_\_\_
- U. If parents are divorced, please give details, including current marital status of each, custody arrangements and current contact with each parent. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- V. Religion (spiritual environment) of family \_\_\_\_\_  
 \_\_\_\_\_

II **PRESENTING PROBLEMS**

Please list and describe the primary issues which have caused you to seek a Psychiatric Evaluation for your child. Be as specific as possible as to the beginning of problems, possible reasons for problems and duration.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In your opinion, how do you feel I can help your child with this (these) problems?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

III **Past History**

A. Birth History

How much did your child weigh at birth? \_\_\_\_\_

At one year? \_\_\_\_\_

Were there any difficulties/complications with the pregnancy, labor or delivery?

If so, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was the pregnancy an unplanned pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Developmental History ( as best you can remember)

1. Motor

Hyperactive in utero? Yes \_\_\_\_\_ No \_\_\_\_\_

Age sat up \_\_\_\_\_

Age crawled \_\_\_\_\_

Age walked without help \_\_\_\_\_

Clumsy? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Right or left-handed? \_\_\_\_\_

“Hyperactive” at an early age? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please elaborate \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Eating

Problems such as colic, loss of weight, allergies, eating peculiarities, or spitting, etc. Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please elaborate \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Social (Infancy to First Grade)

Age first smiled \_\_\_\_\_ Friendly baby? Yes \_\_\_\_\_ No \_\_\_\_\_

Were there any traumatic separations where your child reacted with severe anxiety or withdrawal? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe peer relationships as a pre-schooler \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Language

Age said first word \_\_\_\_\_ First full sentence \_\_\_\_\_

Any language delays? \_\_\_\_\_

Stuttering? \_\_\_\_\_

5. Other

If your child has had or now has any of the following, please explain below

Body rocking \_\_\_\_\_

Head banging \_\_\_\_\_

Failure to thrive (lack of weight gain) \_\_\_\_\_

Sleep problems \_\_\_\_\_

a. Couldn't sleep through the night after 6 months \_\_\_\_\_

b. Nightmares (How often) \_\_\_\_\_

Describe the nature of the nightmares \_\_\_\_\_

c. Insomnia \_\_\_\_\_

d. Sleep walking \_\_\_\_\_

e. Sleep talking \_\_\_\_\_

Unusual fears \_\_\_\_\_

Blank spells \_\_\_\_\_

Tics \_\_\_\_\_

Pica (eating inedible substances after age 2) \_\_\_\_\_

Hair/eyebrow pulling \_\_\_\_\_

Bedwetting (after age 6) \_\_\_\_\_ Day? \_\_\_\_\_

Night? \_\_\_\_\_ Frequency? \_\_\_\_\_

Soiling (after age 6) \_\_\_\_\_

Excessive daydreaming \_\_\_\_\_

Learning disability \_\_\_\_\_

Firesetting \_\_\_\_\_

Hearing problems \_\_\_\_\_

Visual problems \_\_\_\_\_

Attention/Concentration problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. Medical History

List any significant current or past medical problems such as seizures, accidents, hospitalizations, allergies (including food), injuries to head, etc.

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List all medications and please include dosages and times:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

D. School History

Did your child attend Pre-school? \_\_\_\_\_  
If yes, were there any difficulties? \_\_\_\_\_

Did your child attend Kindergarten? \_\_\_\_\_  
If yes, were there any difficulties? \_\_\_\_\_

Did your child encounter any difficulties adjusting to First Grade? \_\_\_\_\_

Describe your child's overall school adjustment in the other grades: \_\_\_\_\_

Have there been conduct problems at school? \_\_\_\_\_  
If yes, please elaborate \_\_\_\_\_

Please list chronologically schools attended and dates:

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Your child's grades on last report card: \_\_\_\_\_

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Has your child ever repeated a grade? \_\_\_\_\_ If yes, which grade? \_\_\_\_\_  
Reason for repeating grade \_\_\_\_\_

E. Social History (Elementary or higher)

Does your child have difficulty getting along with other children? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Does your child have difficulty getting along with parents, teachers or other adult figures? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

F. Interests (Please describe)

What are your child's main interests? \_\_\_\_\_

What does your child like to do for fun? \_\_\_\_\_

Does your child have an interest in, or participate in sports? \_\_\_\_\_  
If yes, which sports? \_\_\_\_\_

On average, how much television does your child watch each day? \_\_\_\_\_

Does your child have any areas of particular accomplishments or talents? \_\_\_\_\_  
If yes, please elaborate \_\_\_\_\_

**IV. FAMILY HISTORY**

A. Has anyone on either side of the family ever been hospitalized for emotional problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please elaborate: \_\_\_\_\_

\_\_\_\_\_

B. Are there any medical or psychiatric disorders that run in your family? \_\_\_\_\_  
If yes, please elaborate \_\_\_\_\_

\_\_\_\_\_

C. If anyone on either side of the family has had any of the following diseases, Please check below and state the relationship to your child:

1. Mental Retardation \_\_\_\_\_

2. Alcoholism \_\_\_\_\_

3. Drug Addiction \_\_\_\_\_

4. Epilepsy \_\_\_\_\_

5. Neurological (Nervous System) Disease \_\_\_\_\_

6. Other \_\_\_\_\_

D. Please describe any previous psychiatric/psychological treatments or therapies for your child \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person completing this form \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

***PLEASE NOTE:***

Under the HIPAA rules, this information will not be released to anyone, unless it is by your written, signed and dated request for us to do so.