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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)_____
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_____
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.

_____
_____
_____
_____
_____
_____
_____
_____
_____

3.

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_____

_____

_____

4.

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_____

5.

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_____
_____
_____
_____
_____

C. Medical History

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

_____
_____
_____
_____

List all present medications and please include dosages and times:

1._____
2._____
3._____
4._____
5. _____
6._____

6.

List all previous medications and effects and side-effects:

1._____
2._____
3._____
4._____

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:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Your child's grades on last report card:_____
_____
_____
Has your child ever repeated a grade?_____If yes, which grade?_____
Reason for repeating grade_____

7.

E. Social History (Elementary or higher)

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

8.

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. Intellectual Developmental Disability_____
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.