

WILLIAM MARTIN, PH.D. P.C.
A Professional Corporation
32122 Camino Capistrano Suite 200
San Juan Capistrano, California 92675
(949)248-7377
(866)805-2796 fax
[**Billmartinphd@msn.com**](mailto:Billmartinphd@msn.com)

CHILD PSYCHOLOGICAL EVALUATION
Parent Questionnaire

In order to ensure the best care, it's important we find out as much as we can about your child. Please read each question carefully and do your best to answer them completely and accurately. Mark "n/a" to questions that do not apply to you. Ideally, both parents will review and assist in filling out this form.

Identification

Name of child: _____
(First) (Middle) (Last)

Address: _____
(Street) (Apt #)

(City) (State) (Zip)

Age _____ Child's date of birth ___/___/___ male___ female___

Child's ethnic background: Caucasian___ African-American___
Asian___ Hispanic___ Other_____

Child's place of birth: _____

Mother Information

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (Apt #)

(City) (State) (Zip)

Date of birth: ___/___/___ Place of birth: _____

Relationship to client:

Biological Parent ____ Step-parent ____ Adopted ____

Home phone number: _____ Business number: _____

Current occupation: _____

Education: _____

Current marital status: _____

Approximately, how many hours a week does the mother spend with the child?

Present Health: Good ____ Not good (please explain) : _____

If deceased, what was the cause of death? _____ Date: _____

Father Information

Name: _____

(First)

(Middle)

(Last)

Address: _____

(Street)

(Apt #)

(City)

(State)

(Zip)

Date of birth: ___/___/___ Place of birth: _____

Home phone number: _____ Business number: _____

Relationship to child:

Biological parent ____ Step-parent ____ Adopted ____

Current occupation: _____

Education: _____

Current marital status: _____

Approximately, how many hours a week does the father spend with the child?

If is deceased, what was the cause of death? _____ Date _____

Does the child spend time in Daycare or with a sitter? No ____
If "Yes", indicate how many hours a week and with whom.

Please list child's Siblings:

<u>Name</u>	<u>Date of Birth</u>
1. _____	___/___/___
2. _____	___/___/___
3. _____	___/___/___
4. _____	___/___/___
5. _____	___/___/___

Who presently lives in the home? _____

Is the neighborhood best described as safe or dangerous? _____

Who assumes major responsibility for care of the child? _____

Referred by: _____

Family Physician: _____

Address of Physician: _____

What do you hope to gain from this consultation?

Appearance

Child's: height _____ weight _____
 hair color _____ eye color _____

The child feels he/she is: underweight____ overweight ____ average ____

Child's poise and posture is: slumped ____ straight____

Is the child's facial expression and eye contact, appropriate while interacting with others? Yes ____ No ____ Don't know ____

Orientation

Is the child often alert and awake? Yes___ No___

Does it seem difficult for the child to orient him/herself to: time, place, purpose, and person? Yes___ No___ Don't know ___

Mannerisms

Do you feel the child is receptive and easy to maintain rapport with? Yes___ No___

The child's overall socialized behaviors are:
appropriate ___ inappropriate ___

Explain:

Does the child ever act out physically toward others? Explain:

—

Does the child exhibit bizarre mannerisms or gestures such as: foot/finger tapping, twitches, ticks, hand wringing, picking, head shaking or rocking? No___
If "Yes," please explain:_____

Speech

Child's rate and amount of speech is: normal ___ excessive ___ deprived ___

Does the child's speech occur with any difficulty? No ___ if "Yes" please explain:

Are the child's verbal responses relevant to specific questions asked? Mostly ___ Sometimes ___ Never ___

Does the child tend to use inappropriate language? Yes ___ No ___

Affect

What best describes the child's emotional state: depressed___ apathetic___ elated___ hostile___ anxious___ tearful___ reserved___ negative___ content___ indifferent ___

Do you feel the child's emotional responses are appropriate to his/her thought content? Yes___ No___

Thought Processes

Does the child often appear confused? Yes ____ No_____

Is the child often or easily distracted? Does he/she need to be told or asked several times before acknowledging? Explain: _____

Does the child's thought processes appear: spontaneous___ constricted___ irrelevant___ poorly organized___

Does the child appear partially coherent with some evidence of formal thought disorder? Yes_____ No_____ Don't know _____

Does the child often have auditory(hearing), visual(seeing), gustatory(tasting), olfactory(smelling), and/or kinesthetic(touching) hallucinations? No ____
If "Yes" please explain: _____

Does the child often have obsessions, paranoid, phobic, homicidal, suicidal thought content? No ____ If "Yes", please explain: _____

Does the child show signs of having memory impairment? Explain: _____

Has the child suffered any head injuries? Yes ____ No ____

If head injury did occur, when did it happen and did the child suffer from neurological delays as a result of the trauma? _____

The child's general fund of knowledge is considered: poor___ adequate___ exceptional___

What best describes the child's insight into his/her past and present problems and issues: limited___ moderate___ substantial___

Present Problem

Please describe the present problem or situation with which you are requesting assistance. _____

When did the present problem first become evident? _____

In what way was your attention drawn to the child's present problem? _____

What, if any, particular events or experiences do you think may have caused or led up to the problem? _____

Is your child's problem more noticeable at home than at school? _____
How does the child's behavior differ at home, school, and in the neighborhood?

Is your child aware of any problem? Discuss how you base your answer.

Does the mother and father agree as to the existence or extent of the problem?
Please explain.

What kinds, if any, measures have been taken to solve the problem? _____

What kind of results were seen from these measures? _____

From what persons, agencies, or hospitals have you sought help in the past?
Please list them chronologically, and also provide dates of contact beginning with pregnancy.

Please tell us about your child. Beginning with your earliest impression of your child, describe what kind of boy/girl he/she is.

Have you noticed any similar condition or personality characteristics between your child and any family member? If "Yes," please describe.

Indicate behaviors or symptoms exhibited by the child:

- | | | |
|---|--|--|
| <input type="checkbox"/> Excessive crying | <input type="checkbox"/> Hitting, biting, scratching | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Excessive nail biting | <input type="checkbox"/> Lying | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Stealing | <input type="checkbox"/> Lethargic |
| <input type="checkbox"/> Thumb-sucking | <input type="checkbox"/> Lying | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Frequent head-banging | <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Personality changes |
| <input type="checkbox"/> Frequent chewing odd objects | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Lack of interest |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Truancy | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> Food fads | <input type="checkbox"/> Phobias | <input type="checkbox"/> Socially withdrawn |
| <input type="checkbox"/> Stuttering | <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Short-tempered |
| <input type="checkbox"/> Bed wetting after age 3 | <input type="checkbox"/> Anxiety states | <input type="checkbox"/> Inability to have fun |
| <input type="checkbox"/> Soiling after age 3 | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Inability to relax |
| <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Trouble with police | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fighting and quarreling | <input type="checkbox"/> Poor appetite | |

Please describe, if any other family members, including mother and father, have had emotional difficulties.

Developmental History of Client

A. Pregnancy

Was the pregnancy planned? Yes _____ No _____

Was the pregnancy desired? Yes ____ No ____

Did the birth occur in a home or hospital? _____

Was the mother physically well during the pregnancy? Yes ____ No ____

Did the mother work during pregnancy? Yes ____ No ____

Was the mother's emotional condition good? Yes ____ No ____

What was the father's role? _____

Did the mother use any drugs (i.e., ETOH, stimulants, hallucinogens, depressants, cigarettes) during pregnancy? Yes ____ No ____

If "Yes," please explain. _____

B. Birth

Was the child delivered naturally? Yes ____ No (explain): _____

Was the child carried to term? Yes ____ No ____

If premature, how many weeks? _____

Was there any testing during pregnancy or fetal monitoring? _____

Child's: birth weight _____ length _____

Approximately, how long did labor last? _____ The first stage? _____

After birth, was there a resuscitator needed? Yes ____ No ____

Were there any further complications? Yes ____ No ____

If "Yes," please briefly describe. _____

Was delivery difficult? Yes ____ No ____

Was labor induced? Yes ____ No ____

Did the mother have: convulsions ____ hemorrhages ____ infections ____ unusual nervousness ____ anything unusual at or soon after childbirth ____

The parents' relationship can be described as: close___ distant___ friendly___ hostile___ erratic___

C. Feeding

Was the child breast fed? Yes ___ No___

If "Yes":

How long? _____ Did mother enjoy nursing? Yes ___ No ___

Ever fear there wasn't enough milk being produced? Yes ___ No ___

Ever fear milk wasn't good enough? Yes ___ No ___

If "No":

Did mother enjoy feeding time? Yes ___ No ___

Did the mother nurse earlier children? Yes ___ No ___

If "Yes," how long? _____

How did breast or bottle feeding go? _____

Were there any feeding difficulties, whether with breast, bottle, or solid foods?
(explain): _____

Did the baby seem eager for his/ her food? Yes ___ No ___

If "No," then please describe the baby's response and attitude (i.e., not interested, slow, etc.)

Did you notice any significant changes in his/her eating habits (likes & dislikes)?

Please describe and list the ages that these changes occurred. _____

—

When the baby vomited, did he/she bring up his/her food in small or large amounts, and was there much force? _____

At what age, did the baby began to suck his/her thumb or finger? _____

How old was the child when he/she stopped? _____ still present? _____

Did you take any measure to get child to stop? Yes ___ No ___
If "Yes," what were they? _____
At what age? _____

Did the baby go through periods of routinely waking-up and crying? _____
If "Yes," during what age(s)? _____
How often did the child wake-up? _____
What was usually the reason? _____

Describe any periods in which he/she had to be held or rocked in order to fall asleep. _____

Did the baby sleep in his/her own room? Yes ___ No ___
If "No," who did the baby sleep with or share a room with? _____

Developmental Landmarks of the Client:

Physical

How old was the child when he/she first held up their head?

How old was the child when he/she first sat up with support? _____

How old was the child when he/she first started rolling over? _____

How old was the child when he/she started reaching for objects? _____

At what age did the child sit alone? _____ After sitting alone how old was the child when he/she started to crawl? _____

At what age could the child stand with support? _____

At what age could the child stand without support? _____

Walking for this child, can be described as easy or difficult? _____

Did you consider him/her to be awkward or clumsy? _____

Generally, babies vary in regard to the amount of activity they show. Which of the following do you think would most nearly describe your child during the first few months of his/her life? (Check One)

_____ The baby showed a lot of activity such as squirming, wiggling, and moving about. He/she was seldom seen in a relaxed position.

_____ The baby showed vigorous activity of the kind described above when awake and when played with, but was equally often observed playing quietly and generally relaxed.

_____ The baby showed very little physical activity, not even showing an increase in movement when hungry or when played with.

Describe and explain the one you checked:

Did the baby respond with approval and/or pleasure when picked up or cuddled?

How did your child behave when he/she became frustrated or disappointed?

Did your child have temper tantrums? Yes _____ No _____
If "Yes," what seemed to be the cause of them?

How did the father handle the temper tantrums? _____

How did the mother handle the temper tantrums? _____

Do the mother and father use the same corrective actions? Yes _____ No _____

When did the temper tantrums stop? _____

When the child cried, how was the situation handled? _____

Was he/she: talked to? Yes ___ No ___
picked up or fondled? Yes ___ No ___
left to cry it out? Yes ___ No ___

scolded or spanked? Yes ___ No ___

Was your child a good/sound sleeper? Yes ___ No ___ Fair ___

Did your child have any sleeping habits, such as rocking him/herself to sleep, hugging a pillow, holding a blanket, etc.? (explain) _____

At what age(s) did this occur? _____ Does it still occur? _____

Did he/she usually wake up at night? Yes ___ No ___ What was usually the reason he/she would awake? _____

How would he/she get back to sleep? _____

Did he/she have nightmares? Yes ___ No ___ During what age(s)? _____

How frequently, did your child have the nightmares? _____

Did your child have any particular fears? _____

Does your child currently have these fears? Yes ___ No ___

Did your child have any frightening experiences? Yes ___ No ___
If "Yes," please describe the experience and his/her reactions.

During the first year of the child's life, was there anything that caused the mother any unhappiness, anxiety, or that placed her under certain strains (even if it had nothing to do with the new baby)? Yes ___ No ___

Please describe. _____

Did the father take an active part in the baby's care, for example: changing diapers, bathing, feeding, etc.? Yes ___ No ___

Please describe. _____

Was your baby sensitive to any kinds of materials, such as:

wool _____

fur _____

silk _____

other _____

If "Yes," at what age(s)? _____

Is your child still sensitive to such materials? Yes _____ No _____

Talking

Did your baby respond to noises? Explain.

Was your baby usually quiet? Yes _____ No _____

Did your baby babble and coo during the first 6 months? Yes _____ No _____

Did your baby respond to speech during his/her first 6 months? Yes _____ No _____

What age did the child speak his/her first words? _____

What were those first words? _____

Did your child use speech and/or vocalization to express needs and wants?

Yes _____ No _____

Were your child's words meaningful? Yes _____ No _____

What age was the first recognizable sentence spoken? _____

What was the recognizable sentence? _____

Does the child need to be urged to speak? _____

Does your child use speech to tell incidents and express plans? Yes _____ No _____

Describe your child's speech when he/she was 3 1/2 years old? _____

Please describe any speech difficulties and circumstances in the child's life that could be connected with the onset of them. _____

In the home the child was raised, what language(s) were spoken? English____
Spanish____ Arabic____ Chinese____ Korean____ Vietnamese____ French____
Other_____

Toilet Training

At what age did toilet training start? _____

At what age was the child completely trained? _____

After mastery, did the child have any wetting or soiling? Yes ____ No ____
If "Yes," what age(s) was he/she? _____

Presently, does the child have any wetting or soiling? Yes ____ No ____
If "Yes," how often? _____

Attachments

Is the child closer to one parent than another? Yes (whom?) _____
No _____

Were there any changes in his/her attachment, and if so, when did they occur?

Did the child cling to mother at an age when his/her playmates began to be independent? (Please specify an age(s)).

Does your child still cling to the mother? Yes ____ No ____

Did your child expect help from parents with putting on clothes for school?

Yes____ No ____

If "Yes," what age(s) was he/she? _____

Did he/she object to particular clothing chosen for him/her? Yes ____ No ____

When did your child become interested in making independent choices, regarding clothing?

Was your child prepared for the birth of new brothers and/or sisters? Explain.

Does the child show a marked preference for one sibling? Yes ___ No ___

How was this preference expressed? _____

Does the child like playing with children of his/her own age group? Yes ___
No ___ One or two friends? _____ Many friends? _____

Were your child's friends from your social group or children the parents did not expect him/her to choose? _____

Is this child considered a leader or follower?

Does the child show a tendency to play with both, boys and girls?

Separation

(Use the example of: hospitalization of parent or child, boarding school, day care, camp, etc.)

How has the child felt and behaved during separation? Has there been any difficulty in getting the child to go to school in the beginning or since? Please describe. _____

Please describe any changes or shifts in child's social relationship. _____

What play activities does your child most enjoy? Mention any hobbies the child has. _____

Education

Name of school: _____

Address: _____ Phone: _____

Principal: _____ Homeroom teacher: _____

Grade: _____ Currently in school? Yes ___ No ___

How old was the child when he/she entered school? _____

List the schools the child has attended: _____

Using the grading scale A-B-C-D-F; generally, what kind of grades does the child earn?

Has the child failed a grade or been held back a grade? Yes ___ No ___

In chronological order, please describe each year of your child's schooling. (You can start with nursery or kindergarten to the present). Please include your child's strengths and weaknesses and his/her attitude toward school as it has developed to the present.

<u>Grade</u>	<u>Descriptions</u>
Kindergarten	_____
1 st	_____
2 nd	_____
3 rd	_____
4 th	_____
5 th	_____
6 th	_____

Has any teacher indicated that the child doesn't apply him/herself fully? Yes ___
No ___

Does your child have any behavioral or emotional problems in school? Yes ___
No ___

Have these problems been recognized at home? Yes ___ No ___

In which areas, does the child show interest and aptitude: Math ___ Reading ___
Science ___ Physical Education ___ Social Studies ___ Other _____

Which of these areas does he/she not succeed: Math ___ Reading ___
Science ___ Physical Education ___ Social Studies ___ Other _____

Does he/she have difficulties concentrating? Yes ___ No ___

Is the child currently in school? Yes ___ No ___

If "Yes," what grade is he/she in? _____

If "Yes," what is his/her favorite subjects? _____

Medical

Has the child been hospitalized before? Yes ___ No ___

If "Yes," how many times? _____

What was the child been hospitalized for? _____

Has the child been rendered unconscious as a result of injury? Yes ___ No ___

Was the doctor called? Yes ___ No ___

What treatment was given and for how long? _____

Did your child show any change in behavior, due to this accident (i.e.,
nervousness, etc.)? _____

Did the child have any operations such as circumcision, tonsillectomy, lancing of
ear drums, appendectomy, others (please list) : _____

At what age did the operation occur? _____

Was any type of anesthetic used? Yes ___ No _____

What was told to the child about the operation before hand? _____

Was the recovery from the operation(s) uneventful? Yes ___ No ___

After the operation(s), how did the child react? scared ___ temper tantrums ___
shyness ___ nightmares ___ others _____

Please indicate if the child has been diagnosed with the following:

<u>Illness</u>	<u>Age</u>	<u>Mild</u>	<u>Severe</u>	<u>Illness</u>	<u>Age</u>	<u>Mild</u>	<u>Severe</u>
Measles				Pleurisy			
Mumps				Tuberculosis			
Whooping cough				Appendicitis			
Scarlet fever				Convulsions			
Small pox				Polio			
Pneumonia				Frequent colds			
Tonsillitis				Stomach upset			
Ear disease				Epilepsy			
Hay fever				Gland trouble			
Asthma				Allergies			
Influenza				Other			

Has your child ever worn glasses or contact lens? Yes ___ No ___

Does your child have any of the following:

Have difficulty grasping objects easily? _____

Have difficulty chewing and swallowing? _____

Have a cleft palate or lip? _____

Have hyperactivity? _____

Have attention problems? _____

Have neurological difficulties? _____

If you have answered "Yes," to any of these, please explain. _____

Please list types of immunization shots and what age your child was at the time of the shots.

Family Background

Please tell us something of the feelings and attitudes of siblings toward the child who is seeking help, and his/her attitudes toward them. How does the child compare in ability to brothers and sisters, and do any of them have special talents? Also, describe any similar emotional disturbances or long periods of poor health, the brothers and sisters may have had, and if so, whether they've improved: -

Describe how you think your child views you as a parent. _____

How has the child grown up compared to his/her siblings? _____

Did the grandparents play a significant role in the child's upbringing? Yes ____

No ____

In addition, did the immediate family play a significant role in the child's upbringing? Yes ____ No ____

Regarding the mother and father, please describe your own background and development, nationality of family, economic condition, and religious affiliation. Also, include information about your own parents, including occupation, education, etc. If the child's grandparents are deceased, please give date and cause of death. Finally, if there's any family illnesses, such as diabetes, mellitus, or heart disease, please explain. _____

What religion was practiced in the child's household? _____

Does the child follow the parents' religious orientation? Yes ___ No ___

In this family, list any members that were involved in the military. _____

Please list significant information dealing with things such as: intelligence, interests, unusual personality traits, mental and neurological illnesses, drinking and drug use, or criminal record for each of the following:

Father: _____

Mother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Brothers and Sisters: _____

Aunts and Uncles: _____

Please describe how and when, you as parents, discipline your children. _____

Which of the following kinds of punishment were/are used: spanking _____
withholding of privileges _____ withholding of approval or show of affection ___-
___ Others: _____

How does your child respond to each of these punishments? _____

___ Who usually punishes the child?

Is punishment frequently needed? Yes ___ No ___ How much?

—

Sexuality

Please describe how you as parents feel about sex. _____

—

What sexual information do you give your children? _____

—

What age did the child show interest about where babies come from? _____

What age did the child show curiosity about the differences in male and female bodies? _____

Has the child been approached by another child or adult in a sexual manner?

Yes ___ No ___

If "Yes," at what age? _____ Describe the incident as well as his/her reactions: _____

—

Does the child currently act in a sexualized manner toward males or females?

Yes ___ No ___

Most children handle and play with their genitals. When, if ever, have you noticed this? Please describe: _____

—

For your daughter, was she talked to about menstruation before it occurred?

Yes ___ No ___ At what age? _____

What kind of information was she given? _____

—

At what age was menarche? _____

How did she react (i.e., shocked, tearful, casual, pleased)? Please list.

—

For your child, was he/she talked to about sexual matters? Yes ___ No ___
By whom? _____

Was there any evidence of sexual dreams? Yes ___ No ___

Was this discussed with your child? Yes ___ No ___

Was there any noticeable changes of behavior during adolescence? Yes ___
No ___

Did his/her attitudes change toward: Parents _____ Friends _____ School _____
Authority _____

Substances

Has the child admitted to trying any of the following substances? Alcohol ___
cocaine ___ crack ___ pot ___ amphetamines ___ heroin ___ depressants ___
hallucinogens ___ other _____

Does the child believe he/she has a problem related to substance usage?
Yes ___ No ___

Has the child ever received treatment for substances? Yes ___ No ___
If "Yes," where and when? _____

Marriage of Parents

How did the child's parents meet? How long did you know each other before
marriage? Were there any special problems (i.e., financial, religious, sexual,
personality, etc.) early in the marriage? If so, please describe and discuss how
you handled them? _____

Have there been any change in marital adjustment since the birth of your
children? Describe and evaluate your current marital adjustment. Discuss how
you agree or disagree on such matters as: raising the children, family finances,
employment, recreation, etc. Please describe the personality traits of your
spouse. Are you both in agreement about seeking professional help for the
child? _____

For each parent, please list and describe types of employment since completing school:

Mother: _____

Father: _____

Mother:

Date of most recent marriage: _____

Separation: _____ Divorce: _____

Prior—Mother married to: _____

Date married: _____ Date terminated: _____

(Please include ALL marriages, divorces, etc.)

Father:

Current date of marriage: _____

Separation: _____ Divorce: _____

Prior—Father married to: _____

Date married: _____ Date terminated: _____

(Please include ALL marriages, divorces, etc.)

Concerning families' moves and vacations, make chronological list of places of residence in relation to child's age: _____

Is there any additional information you'd like to share?

How long did it take you to complete this questionnaire? _____

Do you have any comments concerning this questionnaire?

Thank You

