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# Family Self-Report Form

**Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB** \_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_

**Your Full Name/(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_**

**Relationship/s to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caretaker 1 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_**

**Caretaker 2 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_**

**Other Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_**

**Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_\_\_\_**

**Who referred you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### Primary Care Provider (i.e., pediatrician) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### The information on this form will help me evaluate your child and work with you to develop a treatment plan. This form will be included in your child’s medical record. I hope that you will fill it out as completely as possible.

### YOUR CONCERN/S (Please use back of sheet if necessary.)

Please describe your child’s problem(s) (the concerns that brought you here today.)

### When did these problems begin?

**Please give examples of the problem(s).**

BIRTH HISTORY

Which of the mother’s pregnancies was this (1st, 2nd, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the mother had any miscarriages [ ] yes [ ] no Previous premature baby(ies) [ ] yes [ ] no

**During Pregnancy**

Length of pregnancy in weeks (most babies are born between 38-42 weeks) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Illness/infection/accident Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Medication taken Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Pregnancy planned Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Depression/Stress Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Smoking How much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Alcohol intake How much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Drug intake How much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Labor and Delivery**

[ ] yes [ ] no Induced [ ] yes [ ] no Lasted over 12 hours

[ ] yes [ ] no Cesarean section Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Anesthesia If yes, what type: [ ] Spinal [ ] Epidural [ ] General (asleep)

**Newborn**

Birth weight \_\_\_\_\_\_ Cried right away [ ] yes [ ] no Apgar scores, if known \_\_\_/\_\_\_

[ ] yes [ ] no Complications Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Breast fed If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Went home after \_\_\_\_ days in the hospital

**Infancy**

[ ] yes [ ] no Enjoyed cuddling [ ] yes [ ] no Fussy, irritable

[ ] yes [ ] no More active than other babies [ ] yes [ ] no Sleeping difficulties

[ ] yes [ ] no Colic [ ] yes [ ] no Feeding difficulties

### DEVELOPMENTAL HISTORY

### If you can recall, record the age at which your child reached the following developmental milestones, if you cannot recall, check the appropriate box

**Age Best recollection, if exact age not recalled**

Sat without support \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Crawled \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Stood without support \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Walked without assistance \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Spoke first words \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Spoke phrases \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Spoke sentences \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Bowel trained \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Bladder trained, day \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Bladder trained, night \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

Rode bicycle \_\_\_\_\_ [ ] Early [ ] Normal [ ] Late

CHILD’S MEDICAL HISTORY

[ ] yes [ ] no Ear infections or tubes Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Vision problems Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Headaches Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Seizures Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Fainting Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Meningitis Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Asthma Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Pneumonia Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Heart problems Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Anemia Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Elevated lead levels Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Slow/fast weight gain Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Stomachaches Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Feeding difficulties Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Sleeping difficulties Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Kidney/urinary probls Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Constipation/diarrhea Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Accidents Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Coordination problems Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Head injuries Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Hospitalizations Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Operations Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Allergies Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Alcohol or Drug use Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Alcohol use Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Other health problems Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] yes [ ] no Current medications Please list medications, and doses, below

Medication name Strength How often

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

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

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

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

**For Children with Medical/Health Problems:**

**[ ] Not applicable**

What does your child know about his/her medical problems?

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

How does your child usually react in medical situations (i.e., doctor’s office, hospital visit, etc.)

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

What seems to help your child get through medical procedures, or make it easier for him/her?

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

FAMILY HISTORY

#### Family Outline

#### Who are the adults in the your home?

Mother [ ] birth [ ] adoptive [ ] stepmother [ ] foster mother [ ] not at home

Father [ ] birth [ ] adoptive [ ] stepfather [ ] foster father [ ] not at home

Other [ ] please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How are the other children in the home related to your child?**

[ ] None [ ] Biologic brother/s [ ] Biologic sister/s [ ] Step brother/s

[ ] Step sister/s [ ] Foster siblings [ ] Cousins [ ] Other

Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_\_

**Who are the legal guardians of your child?**

Mother [ ] birth [ ] adoptive [ ] stepmother

Father [ ] birth [ ] adoptive [ ] stepfather

Other [ ] please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Which of following best describes the caretaking adults' relationship?

[ ] Single, never married [ ] Single, but living with someone [ ] Married, living together

[ ] Married, living apart [ ] Married, legally separated [ ] Divorced

[ ] Gay/Lesbian single [ ] Gay/Lesbian partners [ ] Widowed

[ ] Unknown [ ] Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Family Illness History

**Please list all relatives on either side of the family who have had any of the following. Please indicate whether mother’s or father’s side of the family.**

**Relationship to child Mother’s side Father’s side**

Behavior problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Problems with hyperactivity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Problems with attention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Drug or alcohol abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Problems with depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Problems with anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Psychiatric treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Hospitalized psychiatrically \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Psychiatric medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Suicide ideas or attempts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Trouble with the law \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Learning/Speech problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Mental retardation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

Tics and/or Tourette’s syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]

#### Please mark if any of the following events have happened to your child in the PAST TWO YEARS?

[ ] yes [ ] no Moving to a new home [ ] yes [ ] no New brother or sister

[ ] yes [ ] no Change to new school [ ] yes [ ] no Serious illness/injury in family

[ ] yes [ ] no Parents divorce [ ] yes [ ] no Parental fights

[ ] yes [ ] no Mother or father lost job [ ] yes [ ] no Death of a family member

[ ] yes [ ] no Parents separated [ ] yes [ ] no Death of close friend

[ ] yes [ ] no Increased absence of parent [ ] yes [ ] no Sibling leaving home

[ ] yes [ ] no Serious illness in friend [ ] yes [ ] no Parent in trouble with law

[ ] yes [ ] no Parent getting new job [ ] yes [ ] no New stepmother or stepfather

[ ] yes [ ] no Parent going to jail [ ] yes [ ] no Change in parent’s financial status

[ ] yes [ ] no Trouble with brother or sister [ ] yes [ ] no Special recognition for good grades

[ ] yes [ ] no Joining a new club [ ] yes [ ] no Losing a close friend

[ ] yes [ ] no Less arguments with parents [ ] yes [ ] no Male: girlfriend pregnant

[ ] yes [ ] no Losing a job [ ] yes [ ] no Female: getting pregnant

[ ] yes [ ] no Making the honor role [ ] yes [ ] no Getting own car

[ ] yes [ ] no New boyfriend/girlfriend [ ] yes [ ] no Failing a grade

[ ] yes [ ] no More arguments with parents [ ] yes [ ] no Getting a job

[ ] yes [ ] no Getting into trouble with police [ ] yes [ ] no Major personal injury/illness

[ ] yes [ ] no Breaking up with boy-/girlfriend [ ] yes [ ] no Making up with boy-/girlfriend

[ ] yes [ ] no Trouble with teacher [ ] yes [ ] no Boy-/girlfriend having operation

[ ] yes [ ] no Failing to make athletic team [ ] yes [ ] no Being suspended from school

[ ] yes [ ] no Making failing school grades [ ] yes [ ] no Making an athletic team

[ ] yes [ ] no Trouble with class mates [ ] yes [ ] no Getting put in jail

[ ] yes [ ] no Loss of a pet [ ] yes [ ] no Getting a new pet

**SOCIAL HISTORY**

#### School

Grade \_\_\_\_\_ Teacher/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Past Year

**Attendance** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**Quality of work** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**Math ability** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**Reading ability** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**Homework behavior** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**In School Behavior** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

**Friendships** [ ] good [ ]average [ ]poor [ ] good [ ]average [ ]poor

Approximately how many days of school has your child missed this year? \_\_\_\_\_\_

About how many days did he/she miss last year? \_\_\_\_\_\_\_\_

Was your child ever retained in a grade? [ ] yes [ ] no If yes, which grade? \_\_\_\_\_

Do you feel the school meets your child’s needs? [ ] yes [ ] no If yes, please describe.

Special education, tutor, Core evaluation, IEP, etc. [ ] yes [ ] no If yes, please describe

Does your child participate in physical education ? [ ] yes [ ] no

#### Child’s Activities

Playing sports [ ] little or no interest [ ] moderate interest [ ] strong interest

Dancing [ ] little or no interest [ ] moderate interest [ ] strong interest

Building things [ ] little or no interest [ ] moderate interest [ ] strong interest

Drawing/Crafts [ ] little or no interest [ ] moderate interest [ ] strong interest

Listening to music [ ] little or no interest [ ] moderate interest [ ] strong interest

Instrument/singing [ ] little or no interest [ ] moderate interest [ ] strong interest

Using a computer [ ] little or no interest [ ] moderate interest [ ] strong interest

Fishing/hunting [ ] little or no interest [ ] moderate interest [ ] strong interest

Clubs [ ] little or no interest [ ] moderate interest [ ] strong interest

Riding bike [ ] little or no interest [ ] moderate interest [ ] strong interest

Reading/Writing [ ] little or no interest [ ] moderate interest [ ] strong interest

Pets [ ] little or no interest [ ] moderate interest [ ] strong interest

On average, how many hours per day does your child watch television? \_\_\_ hours

On average, how many hours per day does your child play video or computer games? \_\_\_ hours

On average, how many hours per day does your child play with friends? \_\_\_\_ hours

**Please describe your child’s strengths.**

**What feeling does your child MOST OFTEN show when faced with stress or other problems (i.e., anger, fear, sadness, etc.)**

**What seems to help your child deal with stress or problems?**

**What seems to make things worse?**

#### Please briefly describe how you discipline your child?

### CURRENT SYMPTOMS

### In the past months, please circle the 2 if the item is very true or often true for your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

**0= Not True (as far as you know) 1=Somewhat or Sometimes True 2=Very True or Often True**

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

0 1 2 1. Argues a lot | 0 1 2 32. Screams a lot

0 1 2 2. Bragging, Boasting | 0 1 2 33. Secretive, keeps to self

| 0 1 2 34. Self-conscious or easily

0 1 2 3. Complains of loneliness | embarrassed

0 1 2 4. Cries a lot | 0 1 2 35. Sets fires

0 1 2 5. Cruelty, bullying, mean to others | 0 1 2 36. Showing off or clowning

0 1 2 6. Demands a lot of attention | 0 1 2 37. Shy or timid

0 1 2 7. Destroys his/her things | 0 1 2 38. Stares blankly

0 1 2 8. Destroys things belonging to family or others | 0 1 2 39. Steals at home

0 1 2 9. Disobedient at home | 0 1 2 40. Steals outside the home

0 1 2 10. Disobedient at school | 0 1 2 41. Stubborn, sullen, or irritable

0 1 2 11. Doesn’t seem to feel guilty about misbehaving | 0 1 2 42. Sudden changes in feelings

0 1 2 12. Easily jealous | 0 1 2 43. Sulks a lot

0 1 2 13. Fears he/she might think or do something bad | 0 1 2 44. Suspicious

0 1 2 14. Feels he/she has to be perfect | 0 1 2 45. Swearing/obscene language

0 1 2 15. Feels or complains that no one loves him/her | 0 1 2 46. Talks too much

0 1 2 16. Feels others out to get him/her | 0 1 2 47. Teases a lot

0 1 2 17. Feels worthless or inferior | 0 1 2 48. Temper tantrums/hot temper

0 1 2 18. Gets in many fights | 0 1 2 49. Thinks about sex too much

0 1 2 19. Hangs around with others who get in trouble | 0 1 2 50. Threatens people

0 1 2 20. Would rather be alone than with others | 0 1 2 51. Truancy, skips school

0 1 2 21. Lying or cheating | 0 1 2 52. Underactive, slow moving

0 1 2 22. Nervous, high-strung, or tense | 0 1 2 53. Unhappy, sad, or depressed

0 1 2 23. Too fearful or anxious | 0 1 2 54. Unusually loud

0 1 2 24. Feels dizzy | 0 1 2 55. Uses alcohol and/or drugs

0 1 2 25. Feels too guilty | 0 1 2 56. Vandalism

0 1 2 26. Overtired | 0 1 2 57. Withdrawn, doesn’t get

| involved with others

27.Physical problems without known medical cause: | 0 1 2 58. Worries

0 1 2 a. Aches or pains (not headaches) | 0 1 2 59. Is playful or lighthearted

0 1 2 b. Headaches | 0 1 2 60. Has a good sense of humor

0 1 2 c. Nausea, feels sick | 0 1 2 61. Gets along with parents

0 1 2. d. Problems with eyes | 0 1 2 62. Gets along with siblings

0 1 2 e. Rashes or other skin problems | 0 1 2 63. Gets along with other kids

0 1 2 f. Stomachaches or cramps | 0 1 2 64. Is independent

0 1 2 g. Vomiting, throwing up | 0 1 2 65. Likes to stay active

0 1 2 28. Physically attacks people | 0 1 2 66. Has a positive outlook

0 1 2 29. Prefers being with older | 0 1 2 67. Is good at dealing with daily

kids | problems

0 1 2 30. Refuses to talk | 0 1 2 68. Is easygoing or “laid back”

0 1 2 31. Runs away from home | 0 1 2 69. Deals with change well.

#### What do you hope to accomplish with this evaluation?

**Family Self-Report From has been reviewed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_**