

## ADHD Evaluation Parent Questionnaire

Child's Name:  Today's Date:

Address:  Date of Birth:

Home Phone:

School:  Grade:

Teachers:

Phone:  Fax:  Email:

**What questions would you like answered from this evaluation?**

1.
2.
3.

**Medical History:**

**Were there any problems during pregnancy?** YES  NO

(Check all that apply)

- Toxemia  Infection  High Blood Pressure  Bleeding
- Tobacco use  Alcohol use  Recreational Drugs  Prescribed Drugs

**Were there any problems with labor or delivery?** YES  NO

(Check all that apply)

- Difficult Labor  Prolonged Labor  Premature Delivery
- Fetal Distress  Cesarean Section  Breech Delivery

**Did you or your baby have any complications after delivery?** YES  NO

(Check all that apply)

- Seizures  Breathing Problems  Birth Injury
- Oxygen  Infection

**Did your infant have any problems during the first year of life?** YES  NO

(Check all that apply)

Feeding Difficulties  Colic  Sleep Problems

Ear Infections  Injury  Breathing Problems

**Did your child have any problems during the second year of life?** YES  NO

(Check all that apply)

Excessive Temper Tantrums  Behavior Issues

Ear Tubes  Other:

**Did your infant or toddler have any delay in development? (explain)**

**Did your child have any language delays? (explain)**

**At what age did your child...**

Sit up \_\_\_\_\_? Crawl \_\_\_\_\_? Walk \_\_\_\_\_? Speak single words \_\_\_\_\_?

Put 2 words together \_\_\_\_\_? Achieve bladder control \_\_\_\_\_ & bowel control \_\_\_\_\_?

**Was raising your child...** (Check one) Easy  Average  Hard

**Was your child's activity level...** (Check one) Quiet  Average  Overactive

**Has your child had significant health problems?** (please describe)

**Does your child have any of the following behaviors?** YES  NO

(Check all that apply)

Nervous habits  Odd sounds or grunts  Twitches  Odd Postures

Over reaction to touch/sound  Compulsive habits  Other:

**Does your child have any of the following problems?** YES  NO

(Check all that apply)

Appetite Control  Fighting  Difficulty with Authority  Drug Use

Alcohol Use  Suicidal Thoughts  Sleep

**Has your child witnessed abuse?** YES  NO

(Check all that apply)

Physical  Sexual  Emotional  Psychological

**Has your child been abused?** YES  NO

(Check all that apply)

Physical  Sexual  Emotional  Psychological

**Describe the tone in your home:**

**How do you discipline your child?**

How much TV, video games, and other media does your child use?

Do you monitor content of TV and other media used by your Child? (Check One) Yes  No

**Health Status:**

Immunizations:  Last Physical:

Last Vision Check:  Last Hearing Check:

Current Medications:

Allergies:

**Education History:**

Please summarize your child's progress (academic, social, and testing) at each of these grade levels.

<b>Preschool</b>
<b>Kindergarten</b>
<b>Grades 1 - 3</b>
<b>Grades 4 - 6</b>
<b>Grades 7 - 9</b>

**Grades 10 - 12**

**Has your child been in any special education? (Check all that apply & enter duration)**

<input checked="" type="checkbox"/>	Special Ed Type	Duration
<input type="checkbox"/>	Early Childhood/Special Ed	
<input type="checkbox"/>	Learning Disabilities	
<input type="checkbox"/>	Title 1	
<input type="checkbox"/>	Emotional/Behavioral	
<input type="checkbox"/>	Resource Room	
<input type="checkbox"/>	Speech & Language	
<input type="checkbox"/>	Autism Support	
<input type="checkbox"/>	Other	

**Has your child ever been expelled or suspended from school?** (Check one) Yes  No

**Has your child been retained in a grade?** (Check one) Yes  No

**Has your child had any other emotional, behavioral, neurological or learning problems?** (please describe)

**Social History:**

**What do you see as your child's strengths?**

**What are your child's special interests?**

**How does your child relate to siblings?**

**How does your child relate to friends?**

**Does your child have any trouble making or keeping friends?**

**Describe any current concerns about your child's behavior.**

**How do you discipline your child?**

(Check all that apply)

Time Outs

Yelling

Verbal Warnings

Avoidance

Removal of Privileges

Give in

Rewards

Physical Punishment

Other:

**How often does your child respond to commands:**

**How often does your child eventually comply with commands:**

**Do you and your spouse use similar or different discipline techniques?**

**Is there anything else we should know about your child?**

**Family History:**

Mother's Name:  Age:  Education:

Father's Name:  Age:  Education:

Mother's Employment:

Father's Employment:

Are parents... (Check one)      together       divorced       separated

Marriage is... (Check one)      stable       unstable       never married

Who has custody?

**List other children in family**

Childs Name	Age
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Child's Name	Age
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**What are current household stresses?**

**Does your child have relatives with any of the following?**

(Check all that apply)

ADHD

Autism

Bipolar Disorder

Learning Problems

Depression

Tics

Behavior Problems

Anxiety

Chemical Dependency