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.

Preschool
Kindergarten
Grades 1 - 3
Grades 4 - 6
Grades 7 - 9

Grades 10 - 12

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

✕	Special Ed Type	Duration
☐	Early Childhood/Special Ed	
☐	Learning Disabilities	
☐	Title 1	
☐	Emotional/Behavioral	
☐	Resource Room	
☐	Speech & Language	
☐	Autism Support	
☐	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 ☐

Mariage is... (Check one) stable ☐ unstable ☐ never married ☐

Who has custody? _____

List other children in family

Childs Name	Age

Child's Name	Age

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 ☐

Tics ☐ Behavior Problems ☐ Anxiety ☐ Depression ☐ Chemical Dependency ☐