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 by this evaluation?

1. _____
2. _____
3. _____

Medical History:

Were there any problems during pregnancy? Yes No
(Circle those 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
(Circle those 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
(Circle those that apply)

Seizures Breathing Problems Birth Injury

Oxygen Infection

Birth Weight_____Length of Hospital Stay_____

Did your infant have any problems during the first year of life? Yes No
(Circle those that apply)

Feeding Difficulties Colic Sleep Problems

Ear Infections Injury Breathing Problems

Other_____

Did your child have any problems during the second and third years of life? Yes No
(Circle those that apply)

Excessive Temper Tantrums Behavior Issues

Ear tubes Other_____

Did your infant or toddler have any delay in development?

_____

_____

Did your child have any language delay?

_____

_____

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 Easy_____Average_____ Hard_____

Your child's activity level was?

Quiet _____ Average_____ Over Active_____

Has your child had significant health problems?

Please describe:

_____

_____

Does your child have any of the following behaviors? Yes No
(Circle those that apply)

Nervous Habits Odd Sounds or Grunts Twitches

Odd Postures Over Reaction to Touch or Sound

Compulsive Habits Other_____

Does your child have any of the following problems:
(Circle those that apply)

Appetite Control Fighting

Difficulty with Authority Drug Use

Alcohol Use Suicidal Thoughts

Sleep

Has your child witnessed abuse? Yes No

Physical Sexual Emotional Psychological

Has your child been abused? Yes No

Physical Sexual Emotional Psychological

Please describe _____

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? Yes No

Health Status:

Immunizations:_____Last Physical: _____

Last Vision Check: _____Last Hearing Check: _____

Current Medications:_____

Allergies:_____

Educational 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?

Early Childhood/Spec. Ed._____duration_____
Learning Disabilities_____duration_____
Title 1_____duration_____
Emotional/Behavioral _____duration_____
Resource Room_____duration_____
Speech and Language _____duration_____
Autism Support_____duration_____
Other _____duration_____

Has your child ever been expelled or suspended from school? Yes No

Has your child been retained in a grade? 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?
(Please circle)

Time Outs	Yelling
Verbal Warnings	Avoidance
Removal of Privileges	Give in
Rewards	Other_____
Physical Punishment	

How often does your child respond to initial 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: Together _____Divorced _____

Marriage is: Stable: _____ Unstable: _____ Never Married: _____

Who has custody?_____

List other children in family with ages:

_____Age: _____

_____Age: _____

_____Age: _____

_____Age: _____

What are current household stresses? _____

_____

Does your child have relatives with any of the following?
(Please circle)

ADHD	Autism	Bipolar Disorder
Depression	Tics	Behavior Problems
Anxiety	Chemical Dependency	Learning Problems