Initial ADHD Questionnaire

Patient Name: ____________________

Areas of concern? (Check all that apply)

☐ absenteeism	☐ anger control	☐ disobedience	☐ disruptive behavior
☐ immaturity	☐ motivation	☐ peer relationships	☐ risk taking
☐ self esteem	☐ unhappy at school	☐ expressive language	☐ math
☐ memory	☐ motor skills	☐ receptive language	☐ spelling
☐ homework	☐ attention	☐ distractibility	☐ hyperactivity
☐ class work completion	☐ written expression	☐ health problems	☐ inconsistent performance
☐ test taking			

How well is your child performing academically? ____________________

Is your child getting additional services through school or have an IEP? ☐Yes ☐No

Explain: ____________________

____

How is your child's overall behavior at home? ____________________

How is your child's overall behavior at school? ____________________

What medications does your child currently take? ____________________

____

Has your child had a previous evaluation by a mental health professional? ☐Yes ☐No

If yes, provider's name ____________________

Do you have any concerns about your child's diet? ☐Yes ☐No

Do you have any concerns about your child's sleep? ☐Yes ☐No

Has your child had any of the following conditions or problems? (Check all that apply)

☐ Significant allergies/allergic reactions	☐ Head Injury	☐ Seizures or convulsions
☐ Tics	☐ History of meningitis or encephalitis	☐ History of poison or toxin exposure
☐ Bed wetting > 5 years	☐ Stool soiling	☐ Temper outburst
☐ Mood changes	☐ Trouble getting along with peers	☐ Depression
☐ Anxiety	☐ Weight loss or gain	☐ Change in appetite
☐ Heart problems/Disease	☐ High blood pressure	

If you do not understand any of these questions, please ask your nurse.

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Did your child's mother have any medical problems during pregnancy, labor, delivery or post delivery?

____

Do you have any growth or developmental concerns about your child? ______________________________

____

Family History of any of the following? (Check all that apply)

- ☐ Relative with unexplained sudden death
- ☐ Family history of heart rhythm disturbance
- ☐ Family history of high blood pressure
- ☐ Family history of early heart disease

Does/Is your child… (Check all that apply)

- ☐ Have difficulty sleeping
- ☐ Have decreased interest in social activities and hobbies that used to be pleasurable
- ☐ Act impulsively
- ☐ Act as if driven by a motor (always on the go)
- ☐ Have difficulty awaiting turn
- ☐ Blurt answers before question completed
- ☐ Interrupt others
- ☐ Talk excessively
- ☐ Have difficulty engaging in quiet play
- ☐ Run/climb excessively when inappropriate
- ☐ Leave seat when inappropriate
- ☐ Fidget with hands and or squirm in seat
- ☐ Often forgetful in daily activities
- ☐ Easily distracted by extraneous stimuli
- ☐ Often lose/misplace tools needed to complete tasks
- ☐ Dislike/avoid activities that require sustained mental effort
- ☐ Have difficulty organizing work/tasks
- ☐ Fail to follow through on instructions/finish work
- ☐ Often seem not to pay attention when being spoken to
- ☐ Have difficulty sustaining attention in tasks/play
- ☐ Fail to pay close attention/make careless mistakes
- ☐ Have problems with/signs of self injury
- ☐ Cruel to animals
- ☐ Show tendencies for being destructive
- ☐ Have problems with stealing
- ☐ Have problems with lying

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