COMPLETE CHILDREN'S HEALTH

Initial ADHD Form

Child's name _____

Who is with your child today? _____

Please list current medications being taken. _____

_____

Is your child allergic to any medicines? _____
(please list)

_____

Education History:

What school does your child attend? _____

Current grade in school? _____

Who is child's primary teacher? _____

How many teachers does your child have? _____

What grade did school problems start? _____

Is your child currently receiving additional help? _____

Has your child had educational testing? _____

If yes, by whom? _____

Results of testing? _____

Other problems? _____

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

Areas of concern? (please choose from list) _____

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, written expressions, attention, distractibility, hyperactivity, class work completion, homework, health problems, inconsistent performance, test taking.

Does patient have any ongoing medical problems? _____

Any concerns about diet, sleep or exercise? _____

Has patient had any of the following conditions? _____
(please choose from list)

Surgical procedures, significant allergies or allergic reactions, head injury, seizures, convulsions, facial tics or other repeated body movements.

Has the patient had any of the following problems? _____
(please choose from list)

Bed wetting, stool soiling, temper outbursts, mood changes, anxiety, depression, getting along with peers, lying, stealing, fire setting, destructiveness, cruelty to animals, self injury.

Did the mother have any medical problems during pregnancy, labor, delivery or post delivery? _____

Did the patient have difficulty breathing, crying after delivery, have poor color, poor suck, slow growth and development? _____

Has your child been evaluated by a doctor or mental health professional in the past for school or attention problems? _____

If yes, name of provider. _____

Mother's name _____

Occupation _____

Father's name _____

Occupation _____

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

Parent's marital status _____

Who does patient live with? _____

Please list siblings' names and ages. _____

_____

Is there any family history of Attention Deficit Disorder, depression or substance abuse? _____

Who completed this questionnaire? _____

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