



ADHD SCREENING & DEVELOPMENTAL QUESTIONNAIRE: *FOR PARENT TO COMPLETE*

Child's Name: _____ DOB: _____ Grade in School: _____

Today's Date: _____ Form Completed by: _____ Relation to Child: _____

GESTATIONAL RISK FACTORS

Did any of these occur during the pregnancy?

- | | | | |
|--|-----|----|-----|
| <input type="checkbox"/> Mother took medication | Yes | No | N/A |
| <input type="checkbox"/> Mother smoked cigarettes | Yes | No | N/A |
| <input type="checkbox"/> Mother drank alcohol | Yes | No | N/A |
| <input type="checkbox"/> Mother used illicit drugs | Yes | No | N/A |
| <input type="checkbox"/> Premature birth | Yes | No | N/A |
| ○ IF YES, GESTATIONAL AGE: _____ | | | |

DELIVERY RISK FACTORS

How about at the time of birth, did any of these occur?

- | | | | |
|---|-----|----|-----|
| <input type="checkbox"/> Fetal distress | Yes | No | N/A |
| <input type="checkbox"/> Low birth weight (<5 pounds or 2000 g) | Yes | No | N/A |
| <input type="checkbox"/> Anoxia (lack of oxygen, blue baby) | Yes | No | N/A |

INFANT BEHAVIOR

As an infant and toddler, did your child exhibit any of the following?

- | | | | |
|--|-----|----|-----|
| <input type="checkbox"/> High activity level – Unusually active | Yes | No | N/A |
| <input type="checkbox"/> Impulsive | Yes | No | N/A |
| <input type="checkbox"/> Fearful | Yes | No | N/A |
| <input type="checkbox"/> Fearless | Yes | No | N/A |
| <input type="checkbox"/> Accident prone | Yes | No | N/A |
| <input type="checkbox"/> Short attention span | Yes | No | N/A |
| <input type="checkbox"/> Irritable | Yes | No | N/A |
| <input type="checkbox"/> Poor adaptation to change – slow to accept change | Yes | No | N/A |
| <input type="checkbox"/> Colic | Yes | No | N/A |
| <input type="checkbox"/> Have frequent temper tantrums | Yes | No | N/A |
| <input type="checkbox"/> Eating problems | Yes | No | N/A |
| <input type="checkbox"/> Sleep problems | Yes | No | N/A |

- Clumsiness Yes No N/A
- Rigid, tense instead of cuddly Yes No N/A
- Slow to walk Yes No N/A
- Slow to talk Yes No N/A
- Difficult to potty train Yes No N/A

ENVIRONMENTAL RISK FACTORS

As a child or adolescent, did your child experience any of the following?

- Significant financial disadvantage Yes No N/A
- Neglect Yes No N/A
- Extreme family stress Yes No N/A

MEDICAL HISTORY

RISK FACTORS

DID YOUR CHILD HAVE ANY OF THE FOLLOWING?

				IF YES, WAS THIS TREATED?		
Tics	Yes	No	N/A	Yes	No	N/A
Hearing problems	Yes	No	N/A	Yes	No	N/A
Vision problems	Yes	No	N/A	Yes	No	N/A
Lead poisoning	Yes	No	N/A	Yes	No	N/A
Head injury	Yes	No	N/A	Yes	No	N/A

ACADEMIC HISTORY

INDICATE OVERALL PERFORMANCE IN EACH GRADE:

Grade	Academic Performance		
	Poor	Fair	Good
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Grade	Behavioral Performance		
	Poor	Fair	Good
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

DID ANY OF THE FOLLOWING EVER OCCUR?

Place a ✓ in the box to indicate which of the following occurred and at which grade	GRADE LEVEL													
	Pre-K	K	1	2	3	4	5	6	7	8	9	10	11	12
Achieved failing grades														
Retained														
Took special classes														
Evaluated by school														
Labeled by school														
Had learning difficulties														
Received tutorial assistance														
Suspended from school														
Expelled from school														
Reading problems														
Arithmetic problems														
Writing problems														
Performance was variable or unpredictable														
Told wasn't achieving up to his/her potential														
Diagnosed with a learning disability														

PSYCHIATRIC HISTORY

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ADHD OR ADD? **Yes** **No** **N/A**

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS?

- Oppositional Defiant Disorder? Yes No N/A
- Conduct Disorder? Yes No N/A
- Tic Disorders (e.g., Tourettes)? Yes No N/A
- Learning Disorders or Learning Disabilities? Yes No N/A
- Language or Communication Disorders? Yes No N/A
- Eating Disorders (e.g., anorexia or bulimia)? Yes No N/A
- Feeding Disorder (e.g., pica)? Yes No N/A
- Mental Retardation? Yes No N/A
- Pervasive Developmental Disorder or Autism? Yes No N/A
- Enuresis (i.e., bedwetting) Yes No N/A
- Encopresis (i.e., soiling)? Yes No N/A
- Depression? Yes No N/A
- Bipolar Disorder? Yes No N/A
- Separation Anxiety? Yes No N/A

- | | | | | |
|--------------------------|---|-----|----|-----|
| <input type="checkbox"/> | Social Phobia? | Yes | No | N/A |
| <input type="checkbox"/> | Generalized Anxiety Disorder? | Yes | No | N/A |
| <input type="checkbox"/> | Post-Traumatic Stress Disorder? | Yes | No | N/A |
| <input type="checkbox"/> | Obsessive-Compulsive Disorder? | Yes | No | N/A |
| <input type="checkbox"/> | Panic Disorder? | Yes | No | N/A |
| <input type="checkbox"/> | Has seen a counselor, psychologist or psychiatrist for any reason? | Yes | No | N/A |
| <input type="checkbox"/> | Did he/she take medication for any psychological/psychiatric problem? | Yes | No | N/A |

	Medication 1			Medication 2			Medication 3		
Drug Name									
Prescribed By									
Age Started									
Age Stopped									
For what problems									
Total daily dose									
Benefits									
Side Effects									
Are They Currently Taking This Medication?	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A

FAMILY HISTORY RISK FACTORS

Is there anyone in the **Immediate Family** (parents, brothers or sisters) who you think may have or had ADHD, whether or not they were actually diagnosed or treated? *If yes, who?*

RELATIONSHIP TO PATIENT?	DIAGNOSED?			TREATED?		
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A

How about other relatives (aunts, uncles, grandparents, cousins, nieces, nephews) who you think may have or had ADHD? Were they diagnosed and/or received treatment? *If yes, who?*

RELATIONSHIP TO PATIENT?	DIAGNOSED?			TREATED?		
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A
	Yes	No	N/A	Yes	No	N/A

DO ANY OF YOUR RELATIVES HAVE ANY OF THE FOLLOWING PSYCHOLOGICAL/PSYCHIATRIC DISORDERS?

				RELATIONSHIP
Depression	Yes	No	N/A	
Manic-depression (or Bipolar Disorder)	Yes	No	N/A	
Anxiety or lots of worrying	Yes	No	N/A	
Alcohol abuse	Yes	No	N/A	
Other Substance Abuse	Yes	No	N/A	
Conduct problems, trouble with the law	Yes	No	N/A	
Learning problems	Yes	No	N/A	

ADDITIONAL COMMENTS

Please use this space for any further information/comments you wish to share with us about your child or family.

COMPLETED QUESTIONNAIRES MAY BE MAILED, FAXED OR DROPPED OFF TO EITHER OFFICE LOCATION

If faxing, please send to: FAX #: 585-244-9995 (Attention: Holly)

ELMWOOD PEDIATRIC GROUP
 919 Westfall Rd., Bldg. A, Suite 105
 Rochester, NY 14618

ELMWOOD PEDIATRIC GROUP
 1000 Pittsford-Victor Rd.
 Pittsford, NY 14534