*PAPERWORK MAY BE MAILED, FAXED OR DROPPED-OFF
(If faxing, send to: FAX: 585-473-0283 - Attention: Kendra)

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

Today's Date:_____ Child's Name: _____ DOB: _____

Grade in School:_____ Form Completed by:_____ Relation to Child:_____

GESTATIONAL RISK FACTORS

Did any of these occur during the pregnancy?

❑ Mother took medication	Yes	No	N/A
❑ Mother smoked cigarettes	Yes	No	N/A
❑ Mother drank alcohol	Yes	No	N/A
❑ Mother used illicit drugs	Yes	No	N/A
❑ 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?

❑ Fetal distress	Yes	No	N/A
❑ Low birth weight (<5 pounds or 2000 g)	Yes	No	N/A
❑ 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?

❑ High activity level – Unusually active	Yes	No	N/A
❑ Impulsive	Yes	No	N/A
❑ Fearful	Yes	No	N/A
❑ Fearless	Yes	No	N/A
❑ Accident prone	Yes	No	N/A
❑ Short attention span	Yes	No	N/A
❑ Irritable	Yes	No	N/A
❑ Poor adaptation to change – slow to accept change	Yes	No	N/A
❑ Colic	Yes	No	N/A
❑ Have frequent temper tantrums	Yes	No	N/A
❑ Eating problems	Yes	No	N/A
❑ 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:

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

	Behavioral Performance		
Grade	Poor	Fair	Good
K			
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

❑	Social Phobia?	Yes	No	N/A
❑	Generalized Anxiety Disorder?	Yes	No	N/A
❑	Post-Traumatic Stress Disorder?	Yes	No	N/A
❑	Obsessive-Compulsive Disorder?	Yes	No	N/A
❑	Panic Disorder?	Yes	No	N/A
❑	Has seen a counselor, psychologist or psychiatrist for any reason?	Yes	No	N/A
❑	Did he/she take medication or is currently taking medication for any psychological or psychiatric problem?	Yes	No	N/A

- *If so, list medication information below*

	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 **<u>Immediate Family</u>** (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 <u>other relatives</u> (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 THE PATIENTS RELATIVES HAVE ANY OF THE FOLLOWING PSYCHOLOGICAL/PSYCHIATRIC DISORDERS?

				RELATIONSHIP TO PATIENT
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 #: 585-473-0283 (Attention: Kendra)

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