COMPLETE CHILDREN'S HEALTH

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 _____

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 heart disease

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

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

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
☐Bedwetting after 5 years of age
☐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

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? _____

_____

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

☐ have difficulty sleeping
☐ have decreased interest in social activities or hobbies that used to be pleasurable
☐ act impulsively
☐ have problems with lying
☐ have problems with stealing
☐ show tendencies for being destructive
☐ cruel to animals
☐ have problems with/signs of self injury
☐ act as if driven by a motor (always on the go)
☐ have difficulty waiting 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 not seem to pay attention when spoken to
☐ have difficulty sustaining attention in tasks/play
☐ fail to pay close attention/make careless mistakes

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