Parent history to add to Initial Parent Vanderbilt:

Initial ADHD Evaluation Parent Questionnaire

Date:
Name: _____ D.O.B.:_____

I. EDUCATION HISTORY

This section to be completed by Parents
School: Current Grade:
Primary Teacher: Total # of Teachers:
What grade did school problems start?

Is your child currently receiving additional help? SSD Other:
Has your child had educational testing? No: Yes: If yes, by whom?

Results of testing:

Other problems:
Areas of concern:

absenteeism	peer relations	memory	
written expression	classwork completion	anger control	risk taking
motor skills	attention	homework	disobedience
self esteem	reading distractibility	health problems	disruptive behavior
unhappy @ school	receptive language	hyperactivity	inconsistent performance
immaturity	expressive language	retaining information	test taking
motivation	math spelling		

II PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

This section completed by Parents

1. Does the patient have any ongoing medical problems? Yes No

2. Do you have concerns about diet, sleep, exercise? Yes No

3. Has the patient had any of the following conditions: surgical procedures, significant allergies or allergic reactions to medications: head injury, seizures, facial tics or other repeated body movements, meningitis, encephalitis or poisoning of any type? Yes No

4. Has the patient had any of the following problems: bed wetting, stool soiling, temper outbursts, mood changes, anxiety, depression, getting along with peers, lying, stealing, fire setting, and destructiveness, cruelty to animals or self-injury? Yes No

5. Did the mother have any medical problems during pregnancy, labor, delivery or post delivery period? Yes No

6. Did the patient have difficulty breathing or crying after delivery, have poor color, poor suck, slow growth and development? Yes No

7. Is the patient taking any medication at present? Yes No

8. Has your child been evaluated by an MD or mental health professional in the past for school or attentional problems? Yes No

If Yes to any of the above, please comment:

III. SOCIAL / FAMILY HISTORY

This section to be completed by Parents

Mother's name: Father's name:

Occupation: Occupation:

Parents: Married/Divorced/Separated

Patient lives with:

Siblings - names and ages:

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

Yes No

If Yes, please comment: