

Developmental/ADHD Questionnaire

Important: Please mail/fax this completed form to the office prior to your appointment

Name of Child _____ Date of Birth _____

Name of Mother _____ Age _____

Mother's Education _____ Current Employment _____

Name of Father _____ Age _____

Father's Education _____ Current Employment _____

Parents' marital status: Married Separated Divorced Remarried

Siblings and their ages _____

A. Pre and Perinatal History

Did mother take any of the following during pregnancy?

Beer Wine Hard liquor Cigarettes Medications (list below)

Were there any medical problems during pregnancy? _____

Was there any fetal distress during labor? _____

Delivery: Normal Induced Forceps Caesarian Breech

What was the estimated due date? _____ Birth weight _____

Were there any post natal medical problems? _____

B Infancy

Were there any of these early problems?

Poor feeding Vomiting Colic Excessive Sleepiness Poor Sleep

Was (s)he a difficult baby? _____

How would you rate your child's activity level as a toddler?

Very active Active Average Less active Very inactive

What age were these developmental milestones achieved?

Walked _____ Spoke first word (other than "mama" and "dada") _____

Strung two or more words together _____

Did you have any concerns about his/her development? _____

Name of Child _____

Educational History

Please list any preschools attended, approximate dates, and any special services received (e.g., speech or occupational therapy):

Please list schools attended, grade level, and what kind of modified instruction was received (e.g., home tutor; resource room; self contained classroom; adaptive phys. Ed.; speech, occupational, or physical therapy; counseling or psychotherapy provided by school)

School	Grades	Modified instruction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever received psychological testing, either privately or by the school district? Yes/No. If so, please obtain the results of these tests. Please summarize in your own words the results of this testing and the recommendations that were made to you.

Name of Child _____

Has your child had any of the following prior evaluations and/or interventions?
(Please check all that apply)

Child Neurology _____ Child Psychiatry _____

Psychotherapy _____ Medications _____

Past Medical History

Hospitalization: _____

Surgery: _____

Medications: _____

Medication Allergy: _____

- Otitis Media
- Headaches
- Seizures
- Head Injury
- Enuresis
- Encopresis
- Fractures
- Lead intoxication
- Hearing loss
- Visual impairment
- Strabismus
- Asthma
- UTI

Family History

Significant for (Circle and list affected members):

- | | |
|---------------------------|-----------------------------------|
| ADHD | Hearing Loss |
| Learning Disability | Visual Loss |
| Speech Delay | Tourette's Syndrome/tic disorders |
| Mental Retardation | Depression |
| Autism/PDD | Bipolar disorder |
| Seizures | Obsessive-Compulsive Disorder |
| Cerebral Palsy | Consanguinity |
| Alcohol / substance abuse | Other |