

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation.
Part 1: Child Health (continued)



Child's Name & last 4 of [Sponsor's] Social:

HISTORY: Behavioral		
Y	N	1. Did this child cry frequently as an infant?
Y	N	2. Was this child difficult to calm down as an infant?
Y	N	3. Did this child have trouble sleeping as an infant (e.g., was this child fidgety or overly sleepy)?
Y	N	4. Was this child a picky or irregular eater as an infant?
Y	N	5. Did this child have many temper tantrums as a toddler?
Y	N	6. Did you have trouble keeping a babysitter because of this child's behavior?
Y	N	7. Does this child have urine accidents ?
Y	N	8. Does this child have stool / bowel accidents ?
Y	N	9. Does this child often have nightmares ?
Y	N	10. Has this child ever had tics or nervous twitches , such as repeated eye blinking, head jerking, or throat clearing?
Y	N	11. Does this child have any problems falling asleep ? Specify:
Y	N	12. Does this child have any problems staying asleep through the night? Specify:
Y	N	13. Does this child have any problems getting up in the morning? Specify:
Y	N	14. Does this child have frequent stomachaches and headaches ? Specify:
Y	N	15. Does this child have problems with his/her weight ? Specify:

HISTORY: Health		
Y	N	1. Has this child had any major health problems ? Specify:
Y	N	2. Has this child had frequent ear infections ?
Y	N	3. Has this child had any vision / eye or hearing problems? Specify:
Y	N	4. Has this child ever been hospitalized or had surgery ? Specify:
Y	N	5. Has this child lost consciousness or had a serious head injury ? Specify:
Y	N	6. Has this child had meningitis or encephalitis ? Specify:
Y	N	7. Has this child had seizures ?
Y	N	8. Has this child had any difficulties with growth ? Specify:
Y	N	9. Does this child have any birth defects or birthmarks ? Specify:

HISTORY: Family Medical Problems: Is there any one in this child's family with the following:				If yes, how is this person related to this child?
Y	N	Don't Know	1. Neurologic problems	
Y	N	Don't Know	2. Learning or reading difficulty	
Y	N	Don't Know	3. Depression	
Y	N	Don't Know	4. Bipolar Disorder / Manic Depression	
Y	N	Don't Know	5. Schizophrenia	
Y	N	Don't Know	6. History of physical or sexual abuse	
Y	N	Don't Know	7. Alcohol or Drug problems	
Y	N	Don't Know	8. ADHD / ADD (attention problems)	
Y	N	Don't Know	9. Tics or Tourette's disorder	
Y	N	Don't Know	10. Trouble with the law	
Y	N	Don't Know	11. Medications for nerves or emotional problems	
Y	N	Don't Know	12. Thyroid problems	
Y	N	Don't Know	13. Exposure to toxic chemicals	

Medical Provider Use ONLY Behavior: Y N Health: Y N Family Medical History: Y N [Baselines] Tics: Y N Sleep Problems: Y N Stomachache/Headache: Y N Weight: Y N

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation.
Part 2: Child Information



Child's Name & last 4 of [Sponsor's] Social:

HISTORY: Child's Past/Current Treatment

Y	N	1. Has this child ever been diagnosed with ADHD or ADD in the past? If yes: Year ____ Month ____		
Y	N	2. Has this child ever taken medication for ADHD or ADD in the past? If yes, do you know the name, dose, and time(s) of day the medication was given?		
		a. Name	Dose	Time(s) of Day
		b.		
Y	N	3. Has this child ever received psychological counseling for any problems? Specify:		
Y	N	4. Has this child ever been on any long-term medications? Specify:		
Y	N	5. Does this child have any allergies? Specify:		
Y	N	6. Is this child currently taking any medications?		
Y	N	7. Is this child currently taking any vitamins or herbal supplements?		

7. What medication(s), including vitamins or herbal supplements, is this child currently taking?

Name	Dose	Time(s) of Day
a.		
b.		
c.		

8. Are there any professionals (such as doctors, nurses, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) currently involved in this child's care? Please list them and their role in your child's care:

HISTORY: Social

Y	N	1. Have there been any major changes or stresses in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time: Is this stress still occurring? (circle) Yes No		
Y	N	2. Has there been a serious illness or death in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:		
Y	N	3. Has this child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? (circle) Yes No		
Y	N	4. Are any major changes or stresses expected in the future? If yes, please specify:		

Medical Provider Use ONLY Past ADHD Diagnosis: Y N Past ADHD Treatment: Y N Medications: Y N Professionals: Y N Social: Y N

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation. Part 2: Child Information (continued)



Child's Name & last 4 of [Sponsor's] Social: _____

HISTORY: Child's Living Arrangement

1. This child is currently living with (please check one)

Biological mother and biological father

Biological mother

Biological father

Relative (specify relationship): _____

Adoptive parent(s), relative

Does this child know that he / she is adopted? (circle) Yes No

Adoptive parent(s), non-relative

Does this child know that he / she is adopted? (circle) Yes No

Foster parent(s)

How long has this child been in foster care? Year _____ Month _____

How long has this child been living in your household? Year _____ Month _____

Other (specify): _____

2. The **biological** parents of this child are currently (please check one):

Married to each other Year _____ Month _____

Divorced from each other Year _____ Month _____

Separated from each other Year _____ Month _____

Never married to each other

Other (please specify): _____

Not Applicable (please specify): _____

Don't Know

3. How would you describe the **current relationship** between this child's **biological parents**:

Friendly / Amicable

Unfriendly / Conflict ridden

No relationship

Not Applicable (please specify): _____

Don't Know

Y N 4. Are there any **immediate family members** who do not live with this child (biological mother, biological father, or siblings)?
If yes, please specify relationship to child: _____

Y N 5. Is there anything unusual about this child's **living arrangement** that you would like to discuss with the child's doctor?
If yes, please specify: _____

Y N 6. Are the parent(s)/guardian(s) of this child working outside of the home?

Y N 7. Do you have family or social support locally?

7. Please list all people who are currently living in this child's household.

Name:	Relationship to Child:	Age:	Name:	Relationship to Child:	Age:

HISTORY: Military Family

Y N 1. Are you or another parent/guardian of your child currently in the Military?

Y N 2. What Branch: Navy Marine Air Force Army Other (specify): _____

Y N 3. Are any of this child's parent(s)/guardian(s) Active Duty Military? If yes, who (circle): Mother Father Both Other:

Y N 4. Are they deployed or deployable?

5. When did you PCS/Move to this Location? Date: _____

6. When are you due to PCS / Move? Date: _____

Y N 7. Do you live in military housing?

Y N 8. Is this child or other members of this family in the Exceptional Family Member Program?

Medical Provider Use ONLY Issues with Living Arrangements: Y N Military Issues: Y N

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation.
Part 3: Child Behavior



Child's Name & last 4 of [Sponsor's] Social:				
Check the box that best describes your child's behavior over the past 6 months. <i>If your child is currently taking medication, please rate your child's behavior NOT on medication.</i>	Never Rarely 0	Occasionally 1	Often 2	Very often 3
1. Fails to give close attention to detail or makes careless mistakes (e.g., homework).				
2. Has difficulty attending to what needs to be done.				
3. Does not seem to listen when spoken to directly.				
4. Does not follow through when given directions.				
5. Has difficulties organizing tasks and activities.				
6. Avoids, dislikes, or does not want to start tasks.				
7. Loses things necessary for tasks or activities (school assignments, pencils, books).				
8. Is easily distracted by noises or other things.				
9. Is forgetful in daily activities.				
10. Fidgets with hands or feet or squirms in seat.				
11. Leaves seat when he/she is supposed to stay in seat.				
12. Runs about or climbs too much when he/she is supposed to stay seated.				
13. Has difficulty playing or starting quiet games.				
14. Is "on the go" or acts as if "driven by a motor".				
15. Talks too much.				
16. Blurts out answers before questions have been completed.				
17. Has difficulty waiting his/her turn.				
18. Interrupts or bothers others when they are talking or playing games.				
19. Argues with adults.				
20. Loses temper.				
21. Actively disobeys or refuses to follow adult's request or rules.				
22. Bothers people on purpose.				
23. Blames others for his or her mistakes or misbehaviors.				
24. Is touchy or easily annoyed by others.				
25. Is angry or bitter.				
26. Is hateful and wants to get even.				
27. Bullies, threatens, or scares others.				
28. Starts physical fights.				
29. Lies to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. Skips school without permission.				
31. Is physically unkind to people.				
32. Has stolen things that have value.				
33. Destroys others' property on purpose.				

Medical Provider Use ONLY [Often & Very Often count as 1] 1-9=Inattentive; diagnosis >=6/9: ___/9 10-18=Hyperactive; diagnosis >=6/9: ___/9 19-26=Oppositional Defiant Disorder; diagnosis >=4/8: ___/8

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Part 3: Child Behavior (continued)



Child's Name & last 4 of [Sponsor's] Social:				
Check the box that best describes your child's behavior over the past 6 months. <i>If your child is currently taking medication, please rate your child's behavior NOT on medication.</i>	Never Rarely 0	Occasionally 1	Often 2	Very often 3
34. Is physically mean to animals .				
35. Has set fires on purpose to cause damage.				
36. Has broken into someone else's home, business, or car.				
37. Has stayed out all night without permission or runaway from home overnight.				
38. Has used a weapon that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is fearful, anxious, or worried .				
40. Is afraid to try new things for fear of making mistakes.				
41. Feels useless or inferior .				
42. Blames self for problems, feels at fault.				
43. Feels lonely, unwanted, or unloved ; complains that "no one loves me."				
44. Is sad or unhappy .				
45. Feels different and easily embarrassed .				
46. Has problems getting along with you .				
47. Has problems getting along with others his/her own age .				
48. Has problems getting along with his / her own siblings .				
49. Has problems in group activities such as games or team play.				
50. Decreased interest or pleasure in all , or almost all, activities of the day.				
51. Has said things like "I wish I were dead" or has tried to hurt self.				
52. Recurrent excessive distress when separation from home or caretakers.				
53. Has distinct periods of unusually irritable or unusually cheerful mood (different from normal).				
54. Has prolonged temper tantrums (greater than 20-30 minutes).				
55. Hears voices others do not hear.				
56. Has compulsions (e.g. child seems driven to wash hands, count, erase until holes appear).				
57. Has obsessions (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
58. Has tics or nervous twitches (e.g. repeated eye blinking, head jerking, shrugging, or throat clearing).				
59. Has recurrent recollections or dreams of a traumatic event.				
60. Seems to avoid or have phobias of specific people, animals, things or situations.				
61. Seems unaware of others existence, is uninterested in interacting with others .				
62. Has odd, eccentric or unusual preoccupations (e.g. clothing items, toys, neatness)				
63. Appears uninterested in activities children his or her age usually like or participate in.				
64. Has experimented with or abused drugs or alcohol .				

Medical Provider Use ONLY [Often & Very Often count as 1] 27-38=Conduct Disorder; diagnosis >=3/12: ___/12 Below are SCREENINGS for Mental Health Areas Noted:
 SCREENS: 39-45=Anxiety/Depression; concerns if >=3/7 : ___/7 46-49=Social Functioning; concerns if >=1/4: ___/4 50-64=OTHER Mental Health Concerns – any may be significant: ___/15

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation.
Part 4: School History



Child's Name & last 4 of [Sponsor's] Social:		
Name of School:		School District:
Teacher (main):		Principal:
Length of time at present school:	Current Grade:	School Phone:
1. Please describe this child's strongest areas in his/her schoolwork :		2. Please describe this child's weakest areas in his/her schoolwork :
a.		a.
b.		b.
c.		c.

HISTORY: School Intervention

Y	N	1. Has this child been in an Early Intervention program or Special Day Care/Preschool ?
Y	N	2. Has this child had speech, occupational or physical therapy, or an adaptive physical education program ?
Y	N	3. Has this child attended summer school ? If Yes, specify subject(s) / grade(s)?
Y	N	4. Has the school ever discussed this child attending summer school with you? Specify:
Y	N	5. Has this child repeated a grade ? If Yes, specify subject(s) / grade(s)?
Y	N	6. Has the school ever discussed this child repeating a grade with you? Specify:
Y	N	7. Is there a possibility that current grade or subjects will need repeating ? Specify:
Y	N	8. Has this child ever received any special education services (like a 504 Plan or IEP)? Specify:
Y	N	9. Is this child currently receiving any special education services (like a 504 Plan or IEP)? Specify:
Y	N	10. Have any disciplinary actions been taken (detentions, suspension, or expulsion)? Specify:
Y	N	11. Does this child need any special medical assistance ? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **problems reported**?
 If Yes, please **describe** the teacher or parent concerns in the space provided.

		Academics	Behavior
Y	N	1. Preschool	
Y	N	2. Kindergarten and First Grade	
Y	N	3. Second and Third Grade	
Y	N	4. Fourth and Fifth Grade	
Y	N	5. Sixth through Eighth Grade	
Y	N	6. High School	

CURRENT: School Performance Please circle the appropriate number.

	Academics					Behavior					
	Above Average	Average	Problematic			Above Average	Average	Problematic			
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5						

Medical Provider Use ONLY School Intervention: Y N Academic School Problems: Y N Behavior School Problems: Y N School Performance: Y N

INITIAL PARENT QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning Evaluation.
Part 5: Child Summary



Child's Name & last 4 of [Sponsor's] Social: _____

HISTORY: Summary

1. Please **summarize your child's OVERALL functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings-- home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

- 1 **Excellent** functioning / No impairment in settings
- 2 **Good** functioning / Rarely shows impairment in settings
- 3 **Mild** difficulty in functioning / Sometimes shows impairment in settings
- 4 **Moderate** difficulty in functioning / Usually shows impairment in settings
- 5 **Severe** difficulties in functioning / Most of the time shows impairment in settings
- 6 **Needs considerable supervision** in all settings to prevent from hurting self or others
- 7 **Needs 24-hour professional care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

Medical Provider Use Only [Summary = any score of 4 or higher is significant & needs addressing] Impairment of Functioning: Y N

Weight: _____ Height: _____ BP: _____ / _____ Pulse: _____ Vision: _____ Hearing: _____

Provider Signature: _____ Date: _____