ADD/ADHD Initial Evaluation Form

Patient Name: _____
Patient DOB: _____

General

1. Please describe the circumstances that prompted you to have your child evaluated for possible attention issues:

   _____

   _____

2. How old was your child when you or your child's teacher first became concerned about your child?

   _____

School

1. Where does your child attend school?

   _____

2. What grade is your child in?

   _____

3. What is the name of your child's Primary Classroom Teacher?

   _____

4. How does your child feel about school?

   _____

5. Does your child have homework? ___Yes ___No ___Sometimes
6. Is homework a problem for your child? ___Yes ___No ___Sometimes

   If yes, please explain: _____

7. How long is your child's homework supposed to take?

   _____

8. How is your child doing academically?

   _____

Testing

1. Has your child had any standardized testing done at school? (Such as End of Grade Tests)

   ___Yes ___No ___Don't Know

   If yes, please elaborate-when, and what were the results? (It may be helpful to bring any written reports with you to the appointment)

   _____

2. Has your child ever been tested by a psychologist?

   ___Yes ___No ___Don't Know

   If yes, please elaborate-when, and what were the results? (It may be helpful to bring any written reports with you to the appointment)_____

Birth History

1. How much did your child weigh at birth?

   _____lbs _____oz

2. Was your child born: ___Early ___On Time ___Late

   If early or late, how early or late were they? _____

3. Were there any problems with the pregnancy? ___Yes ___No

   If yes, please explain: _____

4. Were there problems in the newborn period? ___Yes ___No

   If yes, please explain: _____

5. Was your baby in the Intensive Care Nursery? ___Yes ___No
   If yes, please explain: _____

Developmental History:

1. Please describe any concerns you have or have had about your child's development:
   _____
   _____
2. As a baby/toddler, your child's gross motor skills (walking, running, climbing, use of large muscles) developed: ___Early ___On Time ___Late
3. As a baby/toddler, your child's fine motor skills (holding/manipulating an object with their fingers) developed: ___Early ___On Time ___Late
4. As a baby/toddler, your child's speech and communication skills developed: ___Early ___On Time ___Late
5. As a baby/toddler, your child's social skills developed: ___Early ___On Time ___Late
6. Did your child have a formal development evaluation as a baby or toddler?
   ___Yes ___No ___Unsure
   If yes, then what were the results? _____
7. Has your child ever had speech, physical, or occupational therapy?
   ___Yes ___No ___Unsure
   If yes, then what were the results? _____

Behavioral History:

1. Please describe any concerns you have about your child's behavior:_____
   _____

Medical History:

1. Please list any medical problems your child has:_____
2. Has your child ever been hospitalized? ___Yes ___No
   If yes, then when and what for? _____
3. Has your child ever had any surgeries? ___Yes ___No
   If yes, then when and what for? _____

Medications:

Is your child taking any medications? ___Yes ___No If yes, please list here:

Medication Name	Dose	How Often

Family History:

1. Any family history of attention problems, ADD, or ADHD? ___Yes ___No
   If yes, please explain:_____
2. List any other diseases that run in the family: _____
   _____

Social History:

1. Who lives in the home with your child? _____
2. Any stressors in your child's life? _____
3. Your child typically goes to bed at _____and wakes up at _____.
   (time) (time)
4. Approximately how many hours a day does your child spend playing video games, being on the computer, and/or watching television? _____