

The Attention Deficit Hyperactivity Disorders Program

DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis of ADHD. It is also helpful to us in our ongoing efforts to conduct research on ADHD. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at the time of your child's appointment.

Please circle the answer or write in your answer for all of the questions. Please ignore the small number that appears by the answers. They are to help us record your answers. Thank you.

PLEASE PRINT

Child's Name _____ Birth Date _____ Age _____

Person Completing Form _____ Your Relationship to Child _____ Today's Date _____

Mother's Name _____ Work Phone _____ Home Phone _____

Address _____

Father's Name _____ Work Phone _____ Home Phone _____

Address _____

Is this your biological adopted adopted step foster other _____ child?
1 2 3 4 5

_____ If adopted, how old was the child when she/he was adopted?

Are you the child's legal guardian: If no, please explain. No Yes

Name of Guardian _____ Work Phone _____ Home Phone _____

Address _____

MOTHER'S MARITAL STATUS

Married

1

How many time have you been married?_____

How long have you been married to your present spouse?_____

Separated

2

How long did you live with your spouse before you separated? _____

How long have you been divorced?_____

Divorced

3

How long were you married to your (last) spouse?_____

How long have you been divorced?_____

Widowed

4

Never Married

5

Other

6

Please explain

FATHER'S MARITAL STATUS

Married

1

How many time have you been married?_____

How long have you been married to your present spouse?_____

Separated

2

How long did you live with your spouse before you separated? _____

How long have you been separated?_____

Divorced

3

How long were you married to your (last) spouse?_____

How long have you been divorced?_____

Widowed

4

Never Married

5

Other

6

Please explain

Referred By:

Phone:

Address:

Child Under Medical Care Of (Pediatrician):

Phone:

Address:

Have you notified the child's physician of your appointment here?

No

Yes

Do you believe this child has it in him/her to exert control over behavior and attention?
Please explain.

No Yes
0 1

Has this child ever been diagnosed by a school psychologist or other professional (e.g. mental health clinician/physician) as having ADHD? If yes, explain.

No Yes
0 1

Has this child ever been previously evaluated for ADHD specifically? If yes, explain.

No Yes
0 1

Has this child received treatment for ADHD? If yes, explain.

No Yes
0 1

Is this child on any kind of medication for ADHD?

No Yes
0 1

Please list the name of the medication and dosage the child is given on a daily basis.

How long has this child been on medication?

Has this child experienced any problems while on medication?

Do any other family members (e.g.. mother, father, brother, sister, aunt, uncle, etc.) suffer from a similar problem with inattentiveness/hyperactivity, or some other type of psychological, emotional, learning problem, and/or nervous disorder, etc.?

No Yes

Family member's relationship to child	Current Age	Type of problem	Severity? e.g. mild, severe	Type of Treatment

CHILD'S EDUCATIONAL PLACEMENT

Name of School	School District	

TYPE OF CLASSROOM PLACEMENT (e.g., regular, ED, LD, Resource Room, etc.)

Approximately how many children are in this child's class?

Check all those official school classifications which apply to this child.

Learning Disabled ₁
 Emotionally Disturbed ₂
 Mentally Retarded/Intellectually Limited ₃
 Other ₇
 Visually Impaired ₄
 Hearing Impaired ₅
 Physically Handicapped ₆

Teacher's Name:	Resource Teacher's Name:
Principal's Name:	School Psychologist and/or Counselor's Name:

The name(s), address and phone numbers of any other person involved in this child's education that you feel we should contact. No Yes

Did this child attend any type of preschool program? If yes, what type of program and at what age did she/he begin, and the frequency of attendance (e.g., nursery school; age 4, 2X/week/2hr., session).

No Yes
0 1

Did this child experience any problems in preschool?
Describe:

No Yes
0 1

Did this child repeat any grades? If yes, which ones and what was the reason for repeating that particular grade.

No Yes
0 1

Did this child fail any subjects? If yes, which ones?

No Yes
0 1

Does this child currently receive any special education services?

No Yes
0 1

If yes, specify type (eg., self-contained class, resource room, reading or math lab, etc.).

Frequency of attendance in special classes (e.g., full-time placement, 1X/day-30min. session).

Please list or discuss any other school problems:

MOTHER'S FAMILY HISTORY

Name:

Birth Date:

Birth Place:

Age:

Religion:

Highest Grade Completed:

Highest Degree:

Were you ever in any type of special education? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with reading? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with writing? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with math? If yes, please explain.

No ₀ Yes ₁

Previous Work History:

FATHER'S FAMILY HISTORY

Name:

Birth Date:

Birth Place:

Age:

Religion:

Highest Grade Completed:

Highest Degree:

Where you ever in any type of special education class? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with reading? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with writing? If yes, please explain.

No ₀ Yes ₁

Have you experienced difficulties with math? If yes, please explain.

No ₀ Yes ₁

Generally, what sort of student were you gradewise?

A/B

B/C

C/D

D/F

Did you repeat any grades? If yes, which ones and what was the reason for repeating the grade.

No Yes
0 1

Did you fail any subjects? If yes, which ones?

No Yes
0 1

Any behavior problems? If yes, please specify.

No Yes
0 1

Any mental health problems for which you have received treatment?
If yes, please describe the problem and the treatment you received.

No Yes
0 1

Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive?

No Yes
0 1

Any medical problems?
If yes, please specify.

No Yes
0 1

If yes, how old was your child when they began?

Do you currently drink alcohol? If yes, what type of alcohol do you drink and how much per day?

No Yes
0 1

Do you smoke cigarettes? If yes, please specify average number of cigarettes per day.

No Yes
0 1

Do you currently use any type of drugs? If yes, what types of drugs do you use and how much per day?

No Yes
0 1

Occupation:

Current Place of Employment:

During which years of child's life have you worked?

Previous Work History:

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy:

Length in months (or weeks) if known _____.

X-ray studies? If yes, when during your pregnancy and what type if x-ray?

No Yes
0 1

Were any medications used during pregnancy? If yes, please specify.

No Yes
0 1

Did you smoke cigarettes during pregnancy? If yes, please specify average number of cigarettes per day.

No Yes
0 1

Did you drink alcohol prior to your pregnancy? If yes, what type of alcohol did you drink and how much did you drink per day?

No Yes
0 1

Do you currently drink alcohol? If yes, what type of alcohol do you drink and how much do you drink per day?

No 0 Yes 1

Did you use any type of drugs during your pregnancy? If yes, what type of drugs did you use and how much did you use per day?

No 0 Yes 1

Do you currently use any type of drugs? If yes, what types of drugs do you use and how much per day do you take?

No 0 Yes 1

Pregnancy complications (check all those that apply).

- | | |
|--|---|
| <input type="radio"/> bleeding
1 | <input type="radio"/> high blood pressure
8 |
| <input type="radio"/> excessive vomiting
2 | <input type="radio"/> sonograms
9 |
| <input type="radio"/> excessive weight gain
3 | <input type="radio"/> rash
10 |
| <input type="radio"/> infections
4 | <input type="radio"/> swelling
11 |
| <input type="radio"/> weight loss
5 | <input type="radio"/> fever
12 |
| <input type="radio"/> kidney trouble
6 | <input type="radio"/> toxemia
13 |
| <input type="radio"/> diabetes
7 | <input type="radio"/> other, please explain
14 |

Delivery:

Type of labor: spontaneous 1 induced 2

If labor was induced, please specify reason for induction:

Type of birth delivery: normal 1 breech 2 cesarean section 3

Duration of labor: _____ hours.

Check all those that apply:

- | | |
|--|---|
| <input type="radio"/> forceps used
1 | <input type="radio"/> baby born in some type of danger
(e.g., cord was around the baby's
neck, heart rate problems, etc.).
Please specify: 4 |
| <input type="radio"/> hemorrhage/excessive blood loss
2 | |
| <input type="radio"/> multiple birth
3 | |

Are there other problems or comments regarding this child's infancy and Early childhood development?

No Yes
0 1

Child's approximate age when she/he began:

Walking _____ months

Talking (single words) _____ years

Talking (short sentences - 2+ words) _____ years

Toilet training: daytime _____ years
nighttime _____ years

Does this child continue to have wetting accidents in bed? (day/night?)

No Yes
0 1

Does this child continue to have wetting accidents in clothing? (day/night?)

No Yes
0 1

Does this child continue to have soiling accidents in bed? (day/night?)

No Yes
0 1

Does this child continue to have soiling accidents in clothing? (day/night?). If yes, please explain.

No Yes
0 1

Overall, do you feel this child developed at a: slow normal rapid rate?
Please explain.

1 0 2

CHILDHOOD DISEASES

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment she/he received and if this child continues to receive treatment for the condition.

Asthma	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Anemia	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Lead poisoning	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Meningitis	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Encephalitis	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Seizures	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Epilepsy	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Hydrocephalus	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Cerebral palsy	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Mental retardation	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Heart problem	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Emotional problems	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Vision difficulties	<input type="radio"/> No	<input type="radio"/> Yes
	0	1
Hearing difficulties	<input type="radio"/> No	<input type="radio"/> Yes
	0	1

Any other handicapping conditions or special health considerations?
If yes, please explain.

No Yes
0 1

Has this child ever been taken to the Emergency room? If yes, please list why your child was taken to the emergency Room and how old he/she was at the time of the visit.

No Yes
0 1

BEHAVIOR RATING FORM (DSM-IV)

Date: ____/____/____

Your name: _____ Relationship to Child: _____

Please complete this form. If a description matches your child, place a check mark in the box which shows how serious it is.

This child.....	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in school work, homework, or other activities.				
Often has difficulty sustaining attention in tasks or play activities.				
Often does not seem to listen to what is being said to him or her.				
Often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).				
Often has difficulties organizing tasks and activities.				
Often avoids or strongly dislikes tasks (such as schoolwork or homework) that require sustained mental effort.				
Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, or toys).				
Is often easily distracted by extraneous stimuli.				
Often forgetful in daily activities.				
Often fidgets with hands or feet or squirms in seat.				
Leaves seat in classroom or in other situations in which remaining seated is expected.				
Often runs about or climbs excessively in situations where it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).				
Often has difficulty playing or engaging in leisure activities quietly.				
Is often "on the go" or often acts as if "driven by a motor".				
Often talks excessively.				
Often blurts out answers to questions before the questions have been completed.				
Often has difficulty waiting in lines or awaiting turn in games or group situations.				
Often interrupts or intrudes on others (e.g., butts into conversations or games).				

**THE FOLLOWING FORMS MUST BE COMPLETED BY YOUR CHILD'S
TEACHER/TEACHERS**

Enclosed is the teacher packet. You should distribute them to each of your child's teacher/teachers who know your child well. Some parents ask a teacher from prior years to complete the packet, especially if that teacher worked particularly closely with your youngster.

You can make as many copies as you wish. If you can only get one or two teachers to complete the forms, make sure they currently teach one of the major subjects (Reading, English, Social Studies, Math) as opposed to an elective (Art, Music, Gym).

You'll need to make sure that these forms get back to us prior to your appointment so that we can process them.

If you have any additional questions about these packets, please call:
DR. LORNE LABEL at (805) 494-6551

EDUCATIONAL/TEACHER SURVEY PARENTAL CONSENT FORM

I hereby give my permission to my child's school to release to the Attention Deficit Hyperactivity Disorders Program information regarding my child's grades, achievement test scores, and behavior. I understand that the appropriate teacher(s) will be asked to complete the questionnaires in this packet.

The ADHD Program also has my permission to share their diagnostic information and treatment recommendations with the designated school personnel. I am aware that this information will be kept highly confidential and reviewed only by the necessary professionals. I understand that releasing individually identifiable information about my child requires my written consent, except as otherwise required by law.

Parents' Name:

Address:

City:

State:

Zip:

Child's Name:

School:

School District:

Address:

City:

State:

Zip:

Teacher's Name: (Current School Year)

Teacher's Name: (Last School Year)

School Principal's Name:

School Psychologist's Name:

Parent's Signature:

Date:

HAP ID #

Child's Name:	Teacher's Name:	Date:
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Does this child present any behavior problems for you in any of these situations? Please circle YES or NO. If YES, indicate how severe the problem is by circling the number that corresponds to the degree of severity.

SITUATION	YES	NO	IF YES, HOW SEVERE?								
			LEAST								MOST
During individual desk work	YES	NO	1	2	3	4	5	6	7	8	9
During small group activities	YES	NO	1	2	3	4	5	6	7	8	9
During free play time in class	YES	NO	1	2	3	4	5	6	7	8	9
During lectures to the class	YES	NO	1	2	3	4	5	6	7	8	9
On field trips	YES	NO	1	2	3	4	5	6	7	8	9
During special assemblies	YES	NO	1	2	3	4	5	6	7	8	9
During movies, filmstrips	YES	NO	1	2	3	4	5	6	7	8	9
During class discussions	YES	NO	1	2	3	4	5	6	7	8	9

Are there other situations where this child presents behavior problems?	YES	NO	If YES, please list the situations and indicate how severe his/her behavior is by assigning a value from 1 to 9
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1)	1	2	3	4	5	6	7	8	9
2)	1	2	3	4	5	6	7	8	9
3)	1	2	3	4	5	6	7	8	9
4)	1	2	3	4	5	6	7	8	9
5)	1	2	3	4	5	6	7	8	9
6)	1	2	3	4	5	6	7	8	9

Note: See Barkley's Attention-Deficit Hyperactivity Disorder: A Clinical Workbook, listed in the resources section, for norms.

Child's Name:	Teacher's Name:	Date:
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Below are a series of questions which ask for your professional judgment about this child. There are no right or wrong answers, rather we are trying to better understand how this child acts in your classroom.

	Not at all	Just a little	Pretty much	Very much
Do you think this child is hyperactive?	1	2	3	4
Do you think this child is inattentive?	1	2	3	4
Is this child easily distracted in the classroom?	1	2	3	4
Does this child act differently in a group setting versus a one-on-one setting?	1	2	3	4
Does this child work at a consistent pace?	1	2	3	4
Does this child need more supervision at the start of a task/project?	1	2	3	4
Does this child talk out of turn?	1	2	3	4
Is this child's desk poorly organized?	1	2	3	4
Does this child record assignments accurately?	1	2	3	4
Does this child frequently not turn in homework assignments?	1	2	3	4
Does this child have difficulty in an academic area? If yes please state which academic areas:	1	2	3	4

Comments: