ADHD Evaluation Supplemental Questions

Birth History: Full Term __ Premature __
Any complications during birth? Yes No

Developmental History:
Was there any concern about developmental delay? Yes __ No __
Are you concerned about increasing clumsiness? Yes __ No __

Medical History:
Any chronic illness? Asthma __ Allergies __
Seizures __ Heart problem __
Others : _____

Any medication taken on a regular basis? _____
(prescribed or over the counter)

Sleep History: What is the usual bedtime? _____
What time does child usually wake up in the morning? _____
Does the child wake up frequently at night? Yes __ No ___
Is there any concern about significant snoring? Yes __ No__

Schedule for the day: Eats breakfast? Yes __ No __
What time does child leave the house for school?
Time of school lunch: ____
Eats school lunch? Yes ___ No ___ Barely ___
What time does child arrive home from school?
Any after school activites?

Family History:
Child lives at home with Father__ Mother__ Brother(s) __ Sister(s)_ Others: ____

Any history of developmental delay or psychiatric issues within the family?

Any history of a cardiac problem in the immediate family?

Stress: Any significant stress or change recently / currently?
Home: _____
School: _____
Friends: _____

Other Behavioral Concerns: (e.g. physically aggresive, verbally abusive, depressed, etc.)