Hyperactivity/ADHD Pre-Exam Questionnaire

In order to understand your child's condition fully, please be as accurate as possible. Thank you.

Child's Name _____ Date of birth_____ Age:_____

Developmental History

1. Were motor and self care milestones met on time? Yes No Not sure

2. Do you consider your child clumsy, showing poor control of body movements or having difficulty learning new
motor skills? Yes_____ No

3. Does your child take any medications. Please describe

4. Does your child have a medical diagnosis. Please list

Occupational History

1. What are your child's favorite activities and things he/she loves doing the most ?

2. What does your child dislike the most?

3. What triggers contribute to difficulty with daily routines?Please describe:

4. Describe your child at present: (circle all that apply):
Mostly quiet / overly active / tires easily / talks constantly / too impulsive / restless / stubborn / resistant to changes / fights frequently / usually happy / frequent temper tantrums / clumsy / difficulty separating from primary caretaker / nervous habits or ticks / falls often / wets bed / wets or soils pants/ poor attention span / unusual fears / rocks self frequently / engages in activity a reasonable length of time / interrupts frequently / more active that siblings or other children same age / a "different child" / sloppy table manners / does not listen / sudden outbursts / excessive number of accidents / does not learn from experience / poor memory /fails to react to loud noises / over reacts to touch / excessive reaction to noise / gets stuck / self stimulation / compulsive rituals / motor or vocal tics / odd postures

5. What are your primary concerns and the primary problems?
Using the scale below circle your level of concern from mildly concerned to severely concerned/frequency of occurrence for your child:

Mild **Moderate** **Severe**

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Safety 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Injury 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Confidence 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Social skills 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Nutrition 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Grades 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Focus 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Strength 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Friendships 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

7. How often do you experience these problems with your child? Constantly Daily Weekly

8. Are any of your family's everyday activities affected? Yes No
- If yes, describe how.

9. What do you think has caused this problem?

10. Approximately when did it start?_____ Is it getting worse, better, or staying the same?

11. Has your child had these problems before? Yes No

Social History

1. Does your child participate in recreational groups programs such as sports, scouts, classes or parties?
Yes No

2. If yes, Circle all that apply:

Poor eye contact/ ignores peers/ ignores coach or leader/ do they pick on others/ do other pick on them/ difficulty following rules and directions/ you worry they will get hurt/ you worry they will hurt others/ tantrum behaviors/ difficult time forming friendships/aggressive/ trouble taking turns/ termed troublemaker/ loner/

Educational History

1. Does your child comprehend directions well? Yes No

2. Has your child had to repeat a grade? Yes No

3. Current Placement Regular class Special ed/IEP Gifted

4. Teacher describes the following as significant classroom problems: (circle all that apply:)/ does not sit in seat / frequently gets up and walks around / won't wait for turn / does not respect the rights of others / does not cooperate well in groups / shouts out, does not wait to be called on / typically does better 1:1 / does not pay attention during circle time or lecture/ struggles with small groups, unstructured play, field trips, special assemblies, class discussions.

5. Please list all other past and current therapy, medical, and psychological services/evaluations:

* On the bottom of this page please describe a typical day for your child from waking till bedtime (including whether it is difficult for your child to get to sleep and stay asleep). Please add any information that will help us know your child better:

Parent Signature:_____Date _____