

ADD/ADHD Complete Patient History

Today's Date: _____ Who Referred You: _____

Patient's Name: _____ Date of Birth _____ Age: _____

Home Phone: _____ Alternate Phone: _____

School: _____ School Phone: _____ Grade: _____

Principal: _____ Teacher(s) _____

Previous School: _____

Mother's Name: _____ Occupation: _____

Marital Status: _____ Highest Grade Finished in School: _____

Father's Name: _____ Occupation: _____

Marital Status: _____ Highest Grade Finished in School: _____

Do parents live in the same the same household? Yes ___ No ___

Other Children in the Family:

Name	Age	Any Medical or School Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In your own words, what is the reason for consulting us?

When was this problem first noticed?

What is your child's main problem area?

Has your child been receiving special resources with school? Which?

Has an Individual Education Plan (IEP) been completed for your child?

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Nursery Stay and First Weeks

Please check any of the following that apply to the baby's first couple of weeks:

- | | |
|---|--|
| <input type="checkbox"/> Respiratory distress | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Phototherapy |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Illness _____ | <input type="checkbox"/> Surgery |

How long did the baby stay in the nursery? _____

Infancy

Please check any of the following that apply to the child's first year:

- | | |
|--|--|
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Problems with a routine |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Was never cuddly |
| <input type="checkbox"/> Cried a lot | <input type="checkbox"/> Breastfed until _____ months |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bottle fed until _____ months |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> Was a source of worry |

Development

Please indicate, as best you remember, the age in months at which your child first:

- | | |
|--|---|
| <input type="checkbox"/> Rolled over _____ | <input type="checkbox"/> Spoke first word _____ |
| <input type="checkbox"/> Sat without support _____ | <input type="checkbox"/> Able to say 4-6 words _____ |
| <input type="checkbox"/> Crawled _____ | <input type="checkbox"/> Spoke 2-3 word sentences _____ |
| <input type="checkbox"/> Walked along furniture _____ | <input type="checkbox"/> Could name 4 body parts _____ |
| <input type="checkbox"/> Used spoon to feed self _____ | <input type="checkbox"/> Toilet trained for daytime _____ |
| <input type="checkbox"/> Dressed without help _____ | <input type="checkbox"/> Could name 4 colors _____ |
| <input type="checkbox"/> Could ride tricycle _____ | <input type="checkbox"/> Developed handedness _____ |

Please check any of the following that apply to your child during the first few years:

- | | |
|--|--|
| <input type="checkbox"/> Much more active than other children | <input type="checkbox"/> Problems with sharing toys |
| <input type="checkbox"/> Learned to do things very quickly | <input type="checkbox"/> Didn't care how others felt |
| <input type="checkbox"/> Dare-devil behavior/had no fear | <input type="checkbox"/> Not affected by discipline |
| <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Unable to follow rules |
| <input type="checkbox"/> Tore up more toys than other children | <input type="checkbox"/> Needed constant attention |
| <input type="checkbox"/> Was aggressive toward other children | <input type="checkbox"/> Wanted to be left alone |
| <input type="checkbox"/> Timid or shy | <input type="checkbox"/> Always testing limits |
| <input type="checkbox"/> Needed rigid daily schedule | <input type="checkbox"/> Many tantrums |
| <input type="checkbox"/> Problems adapting to new situations | <input type="checkbox"/> Rocking or head banging |
| <input type="checkbox"/> Gave up easily when frustrated | <input type="checkbox"/> Problems with sleep |
| <input type="checkbox"/> Wandered away from home frequently | <input type="checkbox"/> Problems with eating |



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- | | | |
|--|---|--|
| <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Hay fever/Allergies | <input type="checkbox"/> Asthma/Eczema | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Growth issues |
| <input type="checkbox"/> Accident prone | | |

Please list any type of testing or evaluation(s) that have been done on your child (i.e., speech, learning style, IQ, etc.)

Please list any lab work that has been done on your child (i.e., genetic, thyroid, CBC, etc.)

Other comments and or questions
