Attention and LEARNING DISORDERS CLINIC
A Division of Carroll Counseling Center

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. 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. 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		
Is this your biological, adopted step, foster or other relationship to child?		
If adopted, how old was the child when he/she was adopted?		
Are you the child's legal guardian? If no, please explain below.	☐ yes ☐ no	
Name of Guardian	Work Phone	Home Phone
Address		

MOTHER'S MARITAL STATUS
☐ Married$_1$ How many times 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
FATHER'S MARITAL STATUS
☐ Married$_1$ How many times 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$_0$ ☐ Yes$_1$	

Have you discussed this child's problems with the physician? ☐ No$_0$ ☐ Yes$_1$
Please list the State University Health Science Center Clinics attended by child/family

OTHERS IN THE HOME			
Name	Age	Birth Date	Relationship to Patient

SIBLINGS WHO HAVE MOVED OUT OF THE HOME			
Name	Age	Birth Date	Relationship to Patient

What are your concerns about this child? What are the difficulties/problems that cause you to seek help at this time?
Do you see this child as being hyperactive or as having problems with attention and concentration? If yes, please explain. ☐ No$_0$ ☐ Yes$_1$

Do you believe this child has it in him/her to exert control over behavior and attention? Please explain. ☐ No$_0$ ☐ Yes$_1$

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$_0$ ☐ Yes$_1$

Has this child ever been previously evaluated for ADHD specifically? If yes, explain. ☐ No$_0$ ☐ Yes$_1$

Has this child received treatment for ADHD? If yes, explain. ☐ No$_0$ ☐ Yes

Is this child on any kind of medication for ADHD? ☐ No$_0$ ☐ Yes$_1$

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$_0$ ☐ Yes$_1$

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	Grade

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$_3$
☐ Visually Impaired$_4$
☐ Hearing Impaired$_5$
☐ Physically Handicapped$_6$

☐ Other$_7$

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$_0$ ☐ Yes$_1$

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$_0$ ☐ Yes$_1$
Did this child experience any problems in preschool? If yes, please describe.	☐ No$_0$ ☐ Yes$_1$
Did this child repeat any grades? If yes, which ones and what was the reason for repeating that particular grade.	☐ No$_0$ ☐ Yes$_1$
Did this child fail any subjects? If yes, which ones?	☐ No$_0$ ☐ Yes$_1$
Does this child currently receive any special education services? If yes, specify type (e.g., self-contained class, resource room, reading or math lab, etc.).	☐ No$_0$ ☐ Yes$_1$
Frequency of attendance in special classes (e.g., full–time placement, 1X/day–30 min. 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 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 the reason for repeating the grade. . ❒ No_0 ❒ Yes_1
Did you fail any subjects? If yes, which ones? ❒ No_0 ❒ Yes_1
Any behavior problems? If yes, please specify. ❒ No_0 ❒ Yes_1
Any mental health problems for which you have received treatment? If yes, please describe the problem and the treatment you received. ❒ No_0 ❒ Yes_1
Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive? ❒ No_0 ❒ Yes_1
Any medical problems? ❒ No_0 ❒ Yes_1 If yes, please specify. If yes, how old was your child when they began?
Your age at the time of your pregnancy with this child _____
TOTAL number of pregnancies_____ | Number of previous pregnancies _____
Number of miscarriages _____ | Number of induced abortions _____
Occupation
Current Place of Employment
During which years of child's life have you worked?