Child's Name: _____

Grade: _____

Birthdate: _____

Referred By: _____

Is Child Adopted? _____

Mother's Information

Name _____

Home Phone # _____

Work Phone _____

May I leave messages? _____

Occupation _____

Home Address _____

_____

_____

Mother's Age _____

Father's Information

Name _____

Home Phone # _____

Work Phone # _____

May I leave messages? _____

Occupation _____

Home Address _____

_____

Father's Age _____

People in household:

(names and ages) _____

_____

_____

_____

_____

Circle items that pertain to your child:

- Diagnosed ADD
- Diagnosed ADHD
- Fidgety
- Extremely active
- Lack of self-control
- Doesn't remember rules
- Easily distracted
- Class clown
- Dreamy
- Isolative
- Sad or sullen
- Cries easily/often
- Excessive fears
- Destructive
- Lying
- Stealing
- Tantrums
- Bullies other kids
- Repeated grade
- Reading problems
- Learning problems
- In Special Ed classes

What changes would you like to see?

_____

_____

_____

_____

_____

_____

_____

_____

_____

I authorize the ADD Diagnosis and Treatement Center to provide psychological service, including testing, for the child named above.

X_____Date_____

(Parent or guardian's signature)

Developmental History

Length of pregnancy: _____

Was delivery normal, breeched, or Cesarean section? _____

Duration of labor: _____

Were there any pregnancy complications? _____

_____

Medications used during pregnancy: _____

_____

Did mother smoke cigarettes during pregnancy? _____

Do parents currently smoke cigarettes? _____

Did mother drink alcohol prior to pregnancy? If yes, what type and how often: _____

_____

Do parents currently drink alcohol? If yes, how much and what type? _____

_____

Did mother use any type of drugs during pregnancy? _____

_____

Do parents currently use any type of drugs? _____

Baby's weight at birth: _____

Baby's length at birth: _____

Infancy and Early Childhood

Please circle all that apply:

Colicky	Did not enjoy cuddling
Feeding problems	Headbanging
Sleeping problems	Accident prone
Restlessness	Active

Child's approximate age when began:

Crawling: _____

Walking: _____

Talking (single words): _____

Speaking short sentences: _____

Toilet training: Daytime _____ Nighttime _____

Childhood

Was there any childhood surgery? _____

_____

Any other hospitalization? _____

_____

Please circle which of the following diseases your child had:

asthma	anemia
lead poisioning	meningitis
encephalitis	seizures
epilepsy	cerebral palsy
recurring ear infections	Other: _____

Medication currently taken:	For:
_____	_____
_____	_____
_____	_____

Name and speciality of doctor who prescribes the medication:

_____

_____

Please list any known learning disabilities or school problems:_____

_____

_____

_____

Does anyone else in the family have similar problems? _____

_____

_____

_____

Please list any unusual or traumatic events in this child's life, and the age at which they occurred:

_____

_____

_____

_____

_____

_____

_____

_____

Please use this space to tell us about anything else that you think is important to know about your child:

_____

_____

_____

_____

_____

_____