3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

ADHD Screening Form

Patient Name:_____ Date of Birth:____/____/_____
Form completed by:_____ Relationship to Child:_____
Date of Form Completion:____/____/_____

Current school/grade: _____/_____
Teacher's name/number: _____ /_____
Counselor's name/number:_____ /_____

Chief Concerns:

Prescription medications:

Name	Dose	Time of Day Taken

Over-the-counter medications (like claritin, zyrtec, etc):

Name	Dose	Time of Day Taken

Supplements (like vitamins, omega-3, melatonin, etc):

Name	Dose	Time of Day Taken

Past Medical History Prenatal/Perinatal Check or answer in space provided.		
Pregnancy and Birth History	*No*	*Yes*
Prenatal vitamins during pregnancy?		
Other medication during pregnancy?		
If yes, what medication (s)?		
Any substance use (alcohol, tobacco, illegal drugs) during pregnancy?		
If yes, which substance?		
If substance use, during which part of pregnancy (trimester or month)?		
Fever during pregnancy?		
Influenza during pregnancy?		
Infection during pregnancy?		
If yes, please provide details:		
Complications during pregnancy?		
If yes, please provide details:		
Medical concerns about this child during pregnancy?		
If yes, please provide details:		
Birth weight:		
Apgar score at 1-minute and 5-minute:		
Delivered at term (38 weeks or more)?		
If preterm, how many weeks of gestation?		
Neonatal problems?		
If yes, please provide details:		
Presumed infection at birth?		
Confirmed infection at birth?		
If yes, what type of infection was found?		
Congenital infection?		
If yes, what type of infection was found?		
Breathing problems at birth?		
If yes, circle which type of support was required: oxygen, CPAP, ventilator		
If ventilator, circle which type: JET, oscillator, regular/conventional, other		
If ventilator of any type, for how long?		
Hemorrhage in/near/around brain?		
If yes, specify location and grade:		
Retinopathy of prematurity?		

Past Medical History By System	No	Yes
General Health Section:		
Obesity?		
Underweight?		
Picky eater?		
Head:		
Head trauma?		
Concussion?		
Eye:		
Eye disease?		
If yes, what type?		
Vision problem?		
If yes, what type?		
Eye doctor's name?		
Ear/Nose/Throat:		
Seasonal allergies?		
To what?		
Year-round allergies?		
To what?		
Recurrent ear infections?		
Recurrent sinus infections?		
Hearing problems?		
If yes, is it correctable?		
ENT doctor's name?		
Enlarged tonsils?		
Enlarged adenoids?		
Sleep apnea?		
Snoring?		
Swallowing difficulty?		
Heart:		
High blood pressure (hypertension)?		
Heart murmur (not innocent/benign/functional)?		
Heart problems?		
Rheumatic fever?		
If yes to any, cardiologist's name?		
Chest pain?		
Palpitations?		
Lungs:		
Asthma?		
Other lung disease?		
If yes, please specify:		
Gastrointestinal:		
Acid reflux (GERD)?		
Constipation?		
Fecal accidents (of stool)		
Feeding problems?		
Genitourinary:		
Daytime urinary accidents?		
Bedwetting after age 6?		
Urinary tract infections?		
Abnormal puberty?		

	No	Yes
Muscles/Limbs:		
Right-handed?		
Left-handed?		
Any impaired or missing limb?		
If yes, which?		
Any impaired balance?		
Any coordination difficulty or clumsiness?		
If yes, diagnosis:		
Any limp or abnormal position during walking?		
Any limp or abnormal position during running?		
Neurology:		
Tic disorder?		
Restless leg syndrome?		
Sleep disorder?		
If yes, what type?		
Febrile seizure?		
Seizure disorder?		
If yes, what type?		
Autism?		
If yes, specify type:		
Asperger's syndrome?		
Sensory Processing Disorder?		
Sensory Integration Disorder?		
Cerebral palsy?		
If yes, specify type:		
Mental retardation?		
Neuromuscular disorder?		
If yes, specify type:		
Neurologist's name?		
Genetics/Metabolism:		
Genetic syndrome?		
If yes, specify type:		
Metabolic disorder?		
If yes, specify type:		
Psychiatric:		
Depression?		
Anxiety?		
Mood disorder?		
Bipolar disorder?		
Conduct disorder?		
Oppositional defiant disorder?		
Obsessive-compulsive disorder?		
Other psychiatric disorder?		
If yes, specify type:		
Development:	*Give Age*	
Age that child first smiled socially?		
Age that child rolled over?		
Age that child first walked?		
Age that child first spoke?		
Age that child first spoke in sentences?		

School History:

1. How is your child's performance in school (i.e. grades/scores)? Circle answer below:
   Poor, below average, average, above average, excellent.
2. How is your child's performance on standardized tests? Circle answer below:
   Poor, below average, average, above average, excellent.
3. How does your child's performance compare to your expectations? Circle answer below:
   Poor, below expectations, as expected, above expectations, exceeds all expectations.
4. Does your child have a known learning disability? No__Yes__ If yes, please specify the learning disability, including date(s) of diagnosis and evaluation and management plan:_____

   _____

   _____

   _____

   _____

7. Are you concerned that your child may have a learning disability? No__Yes__ If yes, please specify the area of concern:_____

   _____

   _____

8. Has your child been penalized with any of the following (Circle all that apply):
   detention / suspension / expulsion / none of these
9. Has your child had any psychoeducational testing? No__Yes__ If yes, specify findings in brief:

   _____

   _____

   _____

   _____

10. Does your child have an IEP in place? No__Yes__
11. Does your child have a 504 plan in place? No__Yes__
12. If yes to question 11 or question 12, please provide or attach a copy of current IEP and/or 504 plan.

Stress History (of child and immediate family):

1. Is there a stress in the family of any type (emotional, marital, financial, etc)? No__ Yes___.
2. Is the child cared for primarily by a parent or a legal guardian (circle appropriate answer)?
   If legal guardian, what is the legal guardian's name and relationship to the child?

   _____
3. For separated or divorced families, who has custody? _____.
   Please provide details of custody arrangement and a copy of custody papers, and complete our "Separated/Divorced Custody Agreement" form:_____

   _____

   _
4. Any stress in the parents' relationship with each other (regardless of marital status)? No__ Yes___
5. If the parents are divorced/separated, is there any stress between parent and partner? No__ Yes___
6. Has the child witnessed any violence? *Circle yes or no.* If yes, please describe briefly:_____

_____

_____

8. Is there any current substance abuse (alcohol or drugs) in a family member? No__ Yes___
9. Are there problematic relationships in or with the immediate family at this time? No__ Yes___
10. Regarding the child, are there any bullying concerns? No__Yes__If yes, is your child the bully or the victim (circle all that apply).
11. As far as you know, are there any peer pressures for your child? No__Yes__ If yes, please explain:

    _____

    _____
12. As far as you know, are there any social pressures for your child? No__Yes__If yes, please explain:

    _____

    _____
13. Has this/your child ever used mind-altering substances (drugs, alcohol, cigarettes, other person's prescription drug)? No__Yes__ If yes, please explain:_____

    _____

Family History	*No*	*Yes*	
Does any family member have any of the following:			*Relationship to child (like "paternal aunt" for father's sister)*
Prescription drug use by parent?			
If so, list medications			
Restless leg syndrome?			
Periodic limb movement disorder?			
Arrhythmia (abnormal heart rhythm or heart beat)?			
Sudden death at age <35 years?			
Unexplained death at age <35 years?			
Death by drowning?			
Death at a young age (<35 years)?			
Sudden heart attack or cardiac death in a young person?			
Sudden death during exercise?			
Cardiomyopathy (floppy or poorly functioning heart)?			
If so, what type?			
Hypertrophic cardiomyopathy?			
Wolf-Parkinson White Syndrome (WPW)?			
Prolonged QT syndrome?			
Short QT syndrome?			
Brugada syndrome?			
Marfan syndrome?			
Medical syndrome?			
If medical syndrome, what type?			
Developmental delay?			
Autism?			
Autistic spectrum disorder?			
Asperger's syndrome?			
Pervasive developmental disorder?			
Sensory processing/integration disorder?			
Cognitive limitations?			
Mental retardation?			
Learning disability?			
ADHD?			
ADD?			
School or academic problems?			
If yes, what type?			
Mood disorder (like depression)?			
Bipolar disorder?			
Anxiety disorder?			
Other mental health problem or mental illness?			
If so, what type?			
Traffic violations?			
Encounters/problems with the law?			
Incarcerations/jailings?			
Tobacco use by parent?			
Alcohol use by parent?			
Substance use by parent?			
Illegal drug use by parent?			

Review of Systems	*No*	*Yes*
Does your child ever complain of chest pain with exercise?		
Does your child ever complain of shortness of breath with exercise?		
Has your child ever fainted (syncope)?		
Does your child experience dizziness or near-fainting?		
Has your child ever fainted or near-fainted with exercise?		
Have you noticed a change in your child's exercise tolerance?		
If so, what is the reason for change in exercise tolerance?		
Has your child ever complained of palpitations (abnormal or fast heart beat)?		
Has your child ever complained of extra or skipped heart bearts?		
Has your child ever had a seizure?		
If so, what type?		
Does your child have tics (makes movements/sounds without knowing) ?		
Does your child frequently snore?		
Does your child have sleep apnea (long pause without breathing)?		
Does your child have restless sleep?		
Does your child have daytime sleepiness?		
Does your child have excessive leg movement during sleep?		
Does your child have a problem going to sleep?		
Does your child have problem staying asleep?		
Does your child resist bedtime?		
Does it take a long time for your child to fall asleep?		
Does your child have nighttime awakenings?		
Does your child have early morning awakenings?		
Does your child have sleep walking?		
Does your child have variable/inconsistent bedtimes?		
Does your child have variable/inconsistent wakeup times?		
Does your child have bedtime routine in place?		
Does your child have electronics in the bedroom?		
Does your child drink/use caffeine?		
What is your child's bedtime?		
What is your child's wakeup time?		
Does your child have mood swings?		
Does your child display disruptive behavior at home or school		
Does your child worry a lot (anxiety)?		
Has your child ever seemed depressed?		
Has your child ever expressed suicidal thoughts, threats or actions?		
Does your child have delusions (believe things that are not real)?		
Does your child smoke cigarettes?		
Does your child use tobacco?		
Does your child drink alcohol?		
Does your child use illegal drugs?		
Does your child use someone else's prescription drugs?		
Does your child have learning difficulties		
Does your child lead exposure?		
Does your child use computer, TV or video game system >2 hours/day?		
Does your child play video games with violent content?		
Does your child watch media/movies rated for older children?		