



Dear Parents,

Your child is being evaluated for attention, school, or behavioral problems. As part of this evaluation, we are asking that you:

STEP ONE:

Complete the parent forms.

Complete the registration form, and

STEP TWO:

Give the school forms to your child's teacher.

- If your child has more than one academic teacher, please make sure TWO Academic teachers fill out the packet (you or the school can copy the forms.)
- **If your child is on summer break or not enrolled in school, you may:**
 - Wait until school resumes, or
 - Have a camp counselor, babysitter, etc fill out the forms.

Collect the school forms from your child's teacher.

STEP THREE:

SCHEDULE AN APPOINTMENT with your child's doctor once you have completed and collected the parent AND teacher forms.

Thank you for your concern and commitment to helping your child. We look forward to working with you.



CHILD REGISTRATION FORM FOR PARENTS

PLEASE PRINT

Child's Name:		Sex: M F	Date of Birth:
Child's Mailing Address:	City:	State/ZIP:	
Home Phone, with area code: ()	Child's Insurance:		
Child's Social Security Number:	Child's Race/Ethnicity:		

Child's Legal Guardian (please circle): Mother Father Both Other (specify):

Mother's Name:	Date of Birth:	Home Phone: ()
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
<i>If applicable:</i> Occupation:	Employer:	
Work Phone: ()	Cell/Pager: ()	

Father's Name:	Date of Birth:	Home Phone: ()
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
<i>If applicable:</i> Occupation:	Employer:	
Work Phone: ()	Cell/Pager: ()	

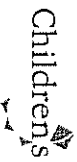
If there is another guardian other than the parents of this child, please complete guardian information below:

Guardian's Name:	Date of Birth:	Home Phone: ()
Relationship to child:	Marital Status: S M W D Sep	
Street Address:	City:	State/ZIP:
<i>If applicable:</i> Occupation:	Employer:	
Work Phone: ()	Cell/Pager: ()	

PARENTS: Before we can evaluate your child, we need to collect information from your child's medical records, school, and other professionals involved in your child's care. We need your permission to do this. Please sign below.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Signature _____ Date _____





PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First):	Date of Birth:	Age:	Sex: M F	Today's Date:
Address:	City:	State:	Zip:	Phone:
Child's Race (circle): 8=Don't know 2=Black or African American 3=White 4=Asian or Pacific Islander 5=American Indian/ Alaskan Native	Is your child also Hispanic or Latino (circle): Yes No	Child's Doctor:	6=Other, specify:	Doctor's Phone:
Name of person completing this form:			Relationship to child:	Phone:

CHIEF CONCERN:

1. Who suggested this child be seen by the doctor for attention, school, or behavior problems?	4. Please circle ONE: Overall, the above concerns are mild, moderate, or severe?	5. Please circle ONE: My concerns are improving, staying the same, or getting worse?
2. What concerns do you have about your child? a. b. c.	6. Please describe this child's strongest areas at home: a. b. c.	7. Please describe this child's weakest areas at home: a. b. c.
3. How long have you been concerned about this child's behavior?		

HISTORY: Birth

Y N	1. How much did this child weigh at birth? _____ pounds _____ ounces	4. Number of pregnancies prior to this child: _____
Y N	2. Biological Father's age at birth of this child: _____	5. Number of miscarriages prior to this child: _____
Y N	3. Biological Mother's age at birth of this child: _____	
Y N	6. Were there any problems during the pregnancy? Specify: _____	
Y N	7. Were there any problems during labor / delivery or following the birth? Specify: _____	
Y N	8. Was this child born by Cesarean / C-Section? If yes, circle appropriate response: planned emergency	
Y N	9. Was this child born two or more weeks before the "due date"? If yes, how many weeks early was this child? _____ weeks	
Y N	10. Were any substances or medications used by the mother during the pregnancy? Beer / Wine _____ Alcohol _____ Any prescription medication _____ Cocaine _____ Tobacco _____ Marijuana _____ Methamphetamine (Crystal / Ice) _____ Other _____ Any prescription medication _____ Cocaine _____ Beer / Wine _____ Alcohol _____ Tobacco _____ Marijuana _____ Methamphetamine (Crystal / Ice) _____ Other _____	
Y N	11. Were any substances or medications used by the father around the time this child was conceived? Beer / Wine _____ Alcohol _____ Any prescription medication _____ Cocaine _____ Tobacco _____ Marijuana _____ Methamphetamine (Crystal / Ice) _____ Other _____	

*HISTORY: Developmental Concerns

Y N	1. Did this child sit up by 8 months?
Y N	2. Did this child crawl by 10 months?
Y N	3. Did this child walk by 15 months?
Y N	4. Did this child speak 2 word sentences by 2 years?
Y N	5. Could strangers understand this child by 3 years?
Y N	6. Did this child stay dry during the day by 3 ½ years?
Y N	7. Did this child read simple words by 6 years?

(OFFICE USE ONLY) Y=Concern 26 months: Y N Birth: Y N 1 *N=Development: Y N 1

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PARENT QUESTIONNAIRE: Child Health (continued)

Child's Name: _____

HISTORY: Behavioral

Y	N	1. Did this child cry frequently as an infant?	
Y	N	2. Was this child difficult to calm down as an infant?	
Y	N	3. Did this child have trouble sleeping as an infant (e.g., was this child fidgety or overly sleepy)?	
Y	N	4. Was this child a picky or irregular eater as an infant?	
Y	N	5. Did this child have many temper tantrums as a toddler?	
Y	N	6. Did you have trouble keeping a babysitter because of this child's behavior?	
Y	N	7. Does this child have urine accidents?	
Y	N	8. Does this child have stool / bowel accidents?	
Y	N	9. Does this child often have nightmares?	
Y	N	10. Has this child ever had ties or nervous twitches, such as repeated eye blinking, head jerking, or throat clearing?	
Y	N	11. Does this child have any problems falling asleep? Specify: _____	
Y	N	12. Does this child have any problems staying asleep through the night? Specify: _____	
Y	N	13. Does this child have any problems getting up in the morning? Specify: _____	
Y	N	14. Does this child have frequent stomachaches and headaches? Specify: _____	
Y	N	15. Does this child have problems with his/her weight? Specify: _____	

HISTORY: Health

Y	N	1. Has this child had any major health problems? Specify: _____	
Y	N	2. Has this child had frequent ear infections?	
Y	N	3. Has this child had any vision / eye or hearing problems? Specify: _____	
Y	N	4. Has this child ever been hospitalized or had surgery? Specify: _____	
Y	N	5. Has this child lost consciousness or had a serious head injury? Specify: _____	
Y	N	6. Has this child had meningitis or encephalitis? Specify: _____	
Y	N	7. Has this child had seizures?	
Y	N	8. Has this child had any difficulties with growth? Specify: _____	
Y	N	9. Does this child have any birth defects or birthmarks? Specify: _____	

HISTORY: Family Medical Problems: Is there anyone in this child's family with the following: _____ If yes, how is this person related to this child?

Y	N	Don't Know	1. Neurologic problems	
Y	N	Don't Know	2. Learning or reading difficulty	
Y	N	Don't Know	3. Depression	
Y	N	Don't Know	4. Bipolar Disorder / Manic Depression	
Y	N	Don't Know	5. Schizophrenia	
Y	N	Don't Know	6. History of physical or sexual abuse	
Y	N	Don't Know	7. Alcohol or Drug problems	
Y	N	Don't Know	8. ADHD / ADD (attention problems)	
Y	N	Don't Know	9. Tics or Tourette's disorder	
Y	N	Don't Know	10. Trouble with the law	
Y	N	Don't Know	11. Medications for nerves or emotional problems	
Y	N	Don't Know	12. Thyroid problems	
Y	N	Don't Know	13. Exposure to toxic chemicals	
Y	N	Don't Know	14. Cardiac problems or sudden death?	

(OFFICE USE ONLY)				
Baseline:	Tics:	Y	N	
	Sleep Problems:	Y	N	
	Health:	Y	N	
	Family Medical History:	Y	N	
	Stomachaches/Headaches:	Y	N	
	Weight:	Y	N	





PARENT QUESTIONNAIRE: Child Information

Child's Name: _____

HISTORY: Child's Past/Current Treatment

Y	N	1. Has this child ever been diagnosed with ADHD or ADD in the past? If yes, Year ____ Month ____						
Y	N	2. Has this child ever taken medication for ADHD or ADD in the past? If yes, do you know the name, dose, and time(s) of day the medication was given?						
		<table border="1"> <tr> <td>a. Name</td> <td>Dose</td> <td>Time(s) of Day</td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> </table>	a. Name	Dose	Time(s) of Day	b.		
a. Name	Dose	Time(s) of Day						
b.								
Y	N	c. Were you satisfied with the medication's effect on this child's symptoms? (circle) Yes No						
Y	N	3. Has this child ever received psychological counseling for any problems? Specify:						
Y	N	4. Has this child ever been on any long-term medications? Specify:						
Y	N	5. Does this child have any allergies? Specify:						
Y	N	6. Is this child currently taking any medications?						
Y	N	7. Is this child currently taking any vitamins or herbal supplements?						

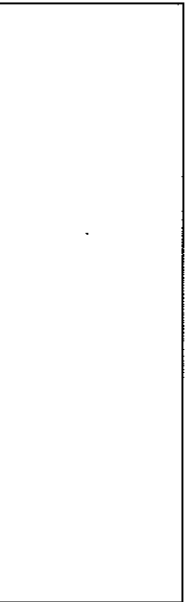
8. What medication(s), including vitamins or herbal supplements, is this child currently taking?		
Name	Dose	Time(s) of Day
a.		
b.		
c.		

9. Are there any professionals (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) currently involved in this child's care? Please list them and their role in your child's care:

HISTORY: Social

Y	N	1. Have there been any major changes or stresses in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time:
		Is this stress still occurring? (circle) Yes No
Y	N	2. Has there been a serious illness or death in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
Y	N	3. Has this child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time:
		Is this trauma still occurring? (circle) Yes No
Y	N	4. Are any major changes or stresses expected in the future? If yes, please specify:

(OFFICE USE ONLY) Adult Dx: Y N Adult Tx: Y N Medications: Y N Professionals: Y N Social: Y N



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PARENT QUESTIONNAIRE: Child Behavior

Child's Name: _____

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*

	Never Rarely 0	Occa- sionally 1	Often 2	Very often 3
1. Fails to give close attention to detail or makes careless mistakes (e.g., homework).				
2. Has difficulty attending to what needs to be done.				
3. Does not seem to listen when spoken to directly.				
4. Does not follow through when given directions.				
5. Has difficulties organizing tasks and activities.				
6. Avoids, dislikes, or does not want to start tasks.				
7. Loses things necessary for tasks or activities (school assignments, pencils, books).				
8. Is easily distracted by noises or other things.				
9. Is forgetful in daily activities.				
10. Fidgets with hands or feet or squirms in seat.				
11. Leaves seat when he/she is supposed to stay in seat.				
12. Runs about or climbs too much when he/she is supposed to stay seated.				
13. Has difficulty playing or starting quiet games.				
14. Is "on the go" or acts as if "driven by a motor".				
15. Talks too much.				
16. Blurts out answers before questions have been completed.				
17. Has difficulty waiting his/her turn.				
18. Interrupts or bothers others when they are talking or playing games.				
19. Argues with adults.				
20. Loses temper.				
21. Actively disobeys or refuses to follow adult's request or rules.				
22. Bothers people on purpose.				
23. Blames others for his or her mistakes or misbehaviors.				
24. Is touchy or easily annoyed by others.				
25. Is angry or bitter.				
26. Is hateful and wants to get even.				
27. Bullies, threatens, or scares others.				
28. Starts physical fights.				
29. Lies to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. Skips school without permission.				
31. Is physically unkind to people.				
32. Has stolen things that have value.				
33. Destroys others' property on purpose.				

(OFFICE USE ONLY) 1-9 ___/9 Inattentive ≥6/9 Dupaul 10-18 ___/9 Hyperactive ≥6/9 Dupaul 19-26 ___/8 Oppositional Defiant Disorder ≥1/8



Modified from the Dupaul ADHD Rating Scale and the Vanderbilt ADHD Diagnostic Parent Rating Scale by the Child and Adolescent Services Research Center (CASRC) in collaboration with the Children's Hospital and Health Center (CHHC) Committee on Guidelines for ADHD in Pediatrics (C-GAP) for use in the San Diego ADHD Project 2003



PARENT QUESTIONNAIRE: Child Behavior (continued)

Child's Name: _____

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*

	Never Rarely 0	Occa- sionally 1	Often 2	Very often 3
34. Is physically mean to animals.				
35. Has set fires on purpose to cause damage.				
36. Has broken into someone else's home, business, or car.				
37. Has stayed out all night without permission or runaway from home overnight.				
38. Has used a weapon that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is fearful, anxious, or worried.				
40. Is afraid to try new things for fear of making mistakes.				
41. Feels useless or inferior.				
42. Blames self for problems, feels at fault.				
43. Feels lonely, unwanted, or unloved; complains that "no one loves me."				
44. Is sad or unhappy.				
45. Feels different and easily embarrassed.				
46. Is overly concerned about health/body.				
47. Has problems getting along with you.				
48. Has problems getting along with others his/her own age.				
49. Has problems getting along with his / her own siblings.				
50. Has problems in group activities such as games or team play.				
51. Decreased interest or pleasure in all, or almost all, activities of the day.				
52. Has said things like "I wish I were dead" or has tried to hurt self.				
53. Recurrent excessive distress when separation from home or caretakers.				
54. Has distinct periods of unusually irritable or unusually cheerful mood (different from normal).				
55. Has prolonged temper tantrums (greater than 20-30 minutes).				
56. Hears voices others do not hear.				
57. Has compulsions (e.g. child seems driven to wash hands, count, erase until holes appear).				
58. Has obsessions (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has recurrent recollections or dreams of a traumatic event.				
60. Seems to avoid or have phobias of specific people, animals, things or situations.				
61. Seems unaware of others existence, is uninterested in interacting with others.				
62. Has odd, eccentric or unusual preoccupations (e.g. clothing items, toys, neatness)				
63. Appears uninterested in activities children his or her age usually like or participate in.				
64. Has experimented with or abused drugs or alcohol.				

(OFFICE USE ONLY) 27-38 ____ / 12 Conduct Disorder ≥ 3 / 12 39-46 ____ / 8 Anxiety/Depression ≥ 3 / 8 47-56 ____ / 4 Social Functioning ≥ 1 / 4 51-64 ____ / 14 Mental Health Concerns

