FOREST LANE
PEDIATRICS

www.forestlanepediatrics.com

Initial Evaluation Questionnaire for ADHD Assessment

Patient's Name: ____________________ Patient's DOB: ______________________

Today's Date: _____________________ Form completed by: __________________

Thank you for allowing us to participate in assessing your child's educational needs. We know that your child's emotional and educational well-being are important to you. **Please complete this document as thoroughly and accurately as possible.** Once this and the other requested documents have been received and reviewed by your child's doctor, your child can be scheduled for an initial behavioral health ADHD visit. During that visit the doctor will review the available information, discuss whether or not your child meets diagnostic criteria for ADHD and review management options.

Requested documents for ADHD Diagnosis and Treatment

1. Initial Evaluation Questionnaire for ADHD Assessment
2. ADHD Policy
3. Vanderbilt Forms from one or more teachers (prefer 2 teachers)
4. Vanderbilt Forms from at least one parent or caregiver (prefer 2 caregivers)
5. Recent report card
6. Any previous evaluations of your child's learning (school IEP, psychoeducational testing, IQ testing, standardized test)

ADHD Web Resources Recommended by Forest Lane Pediatrics

Concerns: (Why do you suspect your child might have ADHD):

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School

Grade: _______________________

Name of school: ________________________

When does school start and end? AM__________ PM__________

Which subjects are difficult for your child?

1. ____________________________
2. ____________________________
3. ____________________________

How many years has your child had trouble with school? ______________________

Has your child ever had to repeat a grade and which grade? No __ Yes __

Which grade? _________________

Has your child had any previous educational evaluation at school or with a psychologist? When: ________________

Who: ________________

*Please provide any documentation from this visit

Does she or he receive any special tutoring or accommodations at the school?

No ___ Yes ___

If Yes:

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Appetite

Would you classify your child as a __ good eater /__ picky eater?

Does he or she take a daily vitamin? No ___Yes ___

What if any special diets have you tried? ____

____

Sleep

What time is bedtime? ________________

What time does your child wake up each morning? ________________

Problems with sleep (falling asleep, waking up, snoring): ___________________

Elaborate: ____

____

Development

Was your child born prematurely? No ___ Yes ___

If yes: How many weeks? ________________

Problems during the pregnancy? ____

____

Problems in the nursery or first month of life? ______________________________________

____

Were there any concerns with development before kindergarten? No ___ Yes ___

Elaborate: ____

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Family

Any major changes at home during the past year (i.e. death in the family, changing schools, etc)? No ___ Yes ___

Elaborate: ____

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Past Heart History

Any history of passing out, racing heart beat, skipped heartbeats, or heart problems?

No ___ Yes ___

Elaborate: ____

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Any family history of sudden unexplained death, heart problems at a young age, or irregular heart beats (arrhythmias)? No ___ Yes ___

If yes, who and what condition? ____

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Any additional information or questions for the doctor? ______________________________

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