LaTouche Pediatrics, LLC

ADD/ADHD Parent Questionnaire

Child's name:		**Grade:**		**DOB:**	
Name of School:		**Referred By:**			

FAMILY HISTORY

Mother		**Father**	
Age		**Age**	
Health		**Health**	
Education		**Education**	
Any problems at school?		**Any problems at school?**	

List all brothers and sisters starting with the oldest first. If any siblings are half siblings, state so. Stepbrothers and sisters need not be listed (only blood relatives).

Name of child:	Grade in school:	How child is doing in school:

Have you lost any child through death or miscarriage?	☐ Yes ☐ No	**If a child died, what did the child die of?**	
Are there any illnesses that run in either side of the family, such as diabetes, etc?			
Is there anybody in the family who has had problems similar to the problems your child is having (include child's grandparents, aunts, uncles, and cousins)?			

PAST HISTORY

BIRTH

Was child full term or premature?		**If premature, how early?**			
Did you have any illness or difficulties with pregnancy?					
Were you on any medications?					
Did you smoke during pregnancy?	☐ Yes ☐ No	**How much?**		**Did you drink alcohol or use drugs?**	☐ Yes ☐ No
How long did labor last?		**Were there any problems with labor?**			
What was the birth weight?		**At what age did he/she leave the hospital?**			
Were there any problems after the child was born?					

FEEDING

Was child bottle or breast fed?		**Any problems with feeding?**	

DEVELOPMENT

At what age did child walk alone?		**At what age did child say phrases?**	
At what age was child toilet trained (not including nights)?		**At what age did child tie shoelaces?**	
At what age did child ride a two-wheel bike (without training wheels)?		**Was your child's development similar to your other children?**	

ILLNESS	
Has your child had any significant illness?	
Has your child ever been hospitalized? ☐ **Yes** ☐ **No** **If so, when, how long, and nature of illness?**	
Has your child had any surgery (not already mentioned above)?	
Has your child had any accidents (including drug accidents and poisonings)?	
Has your child had any allergies?	
Has your child had frequent ear infections? ☐ **Yes** ☐ **No** **If so, at what age?**	

PRESENT HEALTH

Does your child now have any problems, such as headaches, vomiting, bedwetting, or any symptoms which are worrisome to you?

Medications: Has your child ever been treated for ADD/ADHD or depression? ☐ **Yes** ☐ **No**

Medication	Dose	Dates	Are/were they helpful?

SOCIAL HISTORY

With whom does your child live?		**Father's occupation?**		**Mother's occupation?**	

If this is not the first marriage for both parents, please give dates of previous marriages	
If there is a stepparent, boyfriend or girlfriend who lives in the home, please state age, health, and occupation	
Has anything happened in the child's life which you feel might be upsetting to him/her such as illnesses of family members, death of a relative, marital problems, alcoholism, abuse, etc.?	

PRESENT PROBLEM

Please state what you consider to be your child's problem.
How long have you felt that your child has had this problem?

- **As a preschooler, was your child different from your other children?**
- **Is he/she or was he/she ever overactive?**
- **How is his/her attention span?**
- **Does your child have significant behavior problems?**

How do you discipline him/her?
Please include any other aspects of your child's behavior that you feel are important. Examples to illustrate your points are always helpful

Signature: _____ Date: _____