

PEDIATRIC AND ADOLESCENT CENTER OF GRAND PRAIRIE ARLINGTON
ADD/ADHD QUESTIONNAIRE

Pediatric Symptom Checklist

Name: _____

Date: _____

Date of Birth: _____

New Evaluation? Y N

	Never (0)	Sometimes(1)	Often (2)
1. Complains of aches or pains			
2. Spends more time alone			
3. Tires easily, little energy			
4. Fidgety, unable to sit still			
5. Has trouble with teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interest in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on him or herself			
20. Visits doctor with doctor finding nothing wrong			
21. Has trouble with sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feels he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			
Totals			
Grand Total: _____			

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School Basic Information Form

Child's Name: _____ Current Grade: _____

School Name: _____

Address: _____

Phone and Fax #: _____

Contact People at School: *Please circle preferred contact(s):*

Teacher Name: _____ Phone #: _____

Best Times to Call: _____

Principal Name: _____ Phone #: _____

Best Times to Call: _____

Other: _____ Phone #: _____

Best Times to Call: _____

Classroom type: Regular Learning Disabilities (SLD) Developmental Handicap
 Severe behavioral handicap (SBH) Other: (please describe)

What concerns does the school have about this child? (check all that apply):

- Possible Attention Deficit (ADHD)
- Possible Neurological Problems
- Possible medical causes of learning problems
- Possible psychological/emotional problems
- Other (please specify)

Is a learning disability or cognitive delay suspected?

- No learning/cognitive delay suspected
- LD or low IQ suspected (please explain why)

Is child's behavior a problem? No behavior problem

Yes, behavior is a problem (please describe):

Does the child have a current IEP or Accommodation Plan (AP)

- Yes, see attached copy: (Please include any psychological assessments)
- Yes, but copy not available; IEP or AP was done on _____
- No current IEP or AP

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Has a Multifactorial Evaluation (MFE) been requested?

____ Yes, date requested: _____ Requested by: ____ parent ____ teacher ____ other
____ No MFE requested

To convey other information or questions, please use the back or attach sheets.

Parent Questionnaire for School-Age Children: Learning and Attention Issues

Parent/Guardian Name: _____

Today's Date: _____

Child's Name: _____

Age: _____

Please check off the box that corresponds with how much the following descriptions fit your child:

	Yes	No	Don't Know
1. Often makes careless mistakes in school work or chores			
2. Often has short attention span for work or play			
3. Often does not listen			
4. Often starts school work or chores but does not finish, or does not follow instructions			
5. Often disorganizes			
6. Often avoids or dislikes school work or homework that requires sustained mental effort			
7. Often loses pencils, books, or other things he/she needs in order to complete work or hobbies			
8. Is often easily distracted			
9. Is often forgetful			
10. Often fidgety or squirmy - can't keep body still			
11. Often leaves seat in classroom or has hard time sitting through dinner, or religious service (more than other children)			
12. Often runs about or climbs when he/she should be sitting or walking calmly			
13. Rarely plays quietly			
14. Often "on the go" or acts as if "driven by a motor"			
15. Often talks too much, can't keep still when he/she should			

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16. Often blurts out answers to questions			
17. Often cannot wait for his/her turn			
18. Often interrupts conversations, or jumps into games, without waiting for the right time to join in			

1. Have these problems been going on for at least six months? Yes No

2. At what age did these things first become a problem for your child? Yes No

3. Do these problems occur both in school and at home? Yes No

4. Do these problems seriously affect his/her functioning at home? Yes No

5. Do these problems seriously affect his/her ability to make and keep friends? Yes No

6. Do these behaviors cause serious problems in school (for example, unsatisfactory grades, suspensions, frequent notes from the teacher?) Yes No

Questions About Your Child's Behavior: Yes No

7. Is he/she often defiant, angrily refusing to do what you ask? Yes No

8. Is he/she often spiteful or vindictive? Yes No

If so, please explain:

9. Has he/she ever intentionally broken or destroyed something (other than a toy) in anger? Yes No

10. Has he/she ever stolen anything of value? Yes No

If so, please explain:

11. Does he/she often look sad, cry a lot for no reason, or act withdrawn? Yes No

12. Is he/she often irritable (easily annoyed) for no apparent reason? Yes No

Questions About Your Child's Behavior: Yes No

13. Does he/she often say things like "I'm dumb" or "I'm bad" that indicate low self esteem? Yes No

14. Does he/she ever talk about wanting to be dead or wanting to kill himself or herself? Yes No

15. Does he/she have problems separating from you to go to Yes No

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school?

16. Does he/she have any serious fears that get in the way of things he/she should be able to do (for example, being afraid to be in a room alone)? If so, please explain: Yes No

17. Is he/she afraid to fall asleep alone? Yes No

18. Does he/she have frequent nightmares? Yes No

19. Does he/she often have severe mood swings (for example, going from very happy to very sad)? Yes No

20. Does he/she have any unusual habits, or things he/she does compulsively? If so, please explain. Yes No

21. Has he/she ever lost a loved one (for example, a parent died or moved out of the house, or the child went to live away from home for a time)? Yes No

22. Has your child ever been abused, either physically or sexually, or have you ever suspected he/she *might* have been abused? Yes No

23. Has he/she ever witnessed violence, either at home or on the streets (for example, seeing one parent strike or threaten the other, or seeing someone who has been shot or stabbed)? If so, please explain: Yes No

Questions About Your Child's Development and School Work Yes No

24. Do you feel that your child was slow in learning to talk? Yes No

24. Were you ever concerned that his/her mental development might be slow? Yes No

25. Were you ever concerned that his/her mental development might be slow? Yes No

26. Does your child have especially poor coordination (for example, being very clumsy, running into things, exceptionally bad at sports)? Yes No

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- | | | |
|---|-----|----|
| 27. Does your child have particular problems with hand-coordination (for example, holding a pencil, doing buttons or zippers, tying shoes)? | Yes | No |
| 28. Have you ever thought that his/her mental development might be <i>faster</i> or more advanced than other children his/her age? | Yes | No |
| 29. Does he/she have unusual difficulty learning to read or write? | Yes | No |
| 30. Is he/she now failing, or at risk of failing any subjects? | | |
| 31. Does he/she complain that the work is "too easy," and that he/she has "nothing to do" while the other children finish their work? | Yes | No |
| 32. Has he/she ever repeated a grade in school? If yes, please explain? | Yes | No |
| 33. Has he/she ever been expelled from a school or daycare? If yes, please explain? | Yes | No |
| 34. Does he/she often miss four or more days of school per month? If yes, please explain. | Yes | No |
| Questions About Your Child's Health | Yes | No |
| 35. Do you consider him/her basically healthy? If not, please explain. | Yes | No |
| 36. Does he/she have any chronic problems, such as hay fever, allergies, frequent colds, eczema or over-dry skin, or food intolerance? | Yes | No |
| 37. Does he/she take any medications on a regular basis? If so, please explain. | Yes | No |
| 38. Does he/she often complain of headaches (more than once a month)? | Yes | No |
| 39. Does he/she often complain of stomach aches (more than once or twice a month)? | Yes | No |
| 40. Does he/she often or usually snore at night? | Yes | No |

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- | | | |
|---|-----|----|
| 41. Does he/she have a problem with sleeping (sleeps too little or too much, wakes up in the middle of night or early in morning; trouble falling asleep)? If so, please explain. | Yes | No |
| 42. Does he/she have a problem with a constipation (large, hard BMs, or BMs less often than once every 3 days)? | Yes | No |
| 43. Do you ever notice BMs or stains of stool (feces) in his/her underpants? | Yes | No |
| 45. Does he/she ever have tics? (Tics are muscle twitches, often of the face, head, or hands, or unusual vocal noises like barking or coughing when he/she isn't sick.) | Yes | No |
| 46. Does he/she ever have staring spells when he/she will <i>not</i> respond to being touched on the arm? | Yes | No |
| 47. Has he/she ever been seriously injured? (Include any injury, but especially if he/she was knocked out or injured in the head) If so, please explain. | Yes | No |
| 48. Has he/she ever had a problem with high lead levels in the blood? If yes, how high was it? _____ | Yes | No |
| 49. Does he/she ever complain of difficulty seeing or hearing, or failed a vision or hearing test? | Yes | No |
| Questions About Your Family | Yes | No |
| 50. Was anyone in the family "hyper" as a child, or did they (or do they now) have a diagnosis of hyperactivity or attention deficit disorder? If so, please explain. | Yes | No |
| 51. Does your child's behavior remind you of any relative in particular (for example, he/she behaves just like a particular aunt or uncle)? If so, please explain. | Yes | No |
| 52. Does anyone in the family have a problem with tics (muscle twitches), or have diagnosis of Tourette's syndrome? | Yes | No |
| 53. Does anyone in the family have a neurological problem, such as seizures or epilepsy (fits)? | Yes | No |
| 54. Has anyone in the family required treatment for Depression | Yes | No |

or for Bipolar (manic-depressive) Disorder? If so, please explain.

55. Has anyone in the family required treatment for an Anxiety Disorder (such as panic attacks, or extreme fears or nervousness, or a "breakdown")? If so, please explain. Yes No

56. Is there any other history of mental or emotional problems in the family? If so, please explain. Yes No

57. Has anyone in the family had a problem with alcohol - drinking too much, or becoming drunk, or drinking even though it caused problems? Yes No

58. Has anyone in the family had a problem with drug use? Yes No

Questions About Your Efforts So Far Yes No

59. Have you talked with other parents with hyperactive children about what worked for them? Yes No

60. Would you like to? Yes No

61. Have you read any articles, pamphlets, or books about hyperactivity or attention deficit disorder? If yes, were these useful? How? Yes No

62. Has your child been seen in the past by a psychologist, psychiatrist, counselor, or other similar professional? Yes No

63. Have you already requested a *multi-factored evaluation* from your child's school? If so, please explain what happened: Yes No

64. Do you feel you have a good relationship with the school (if you feel there is a lot of tension between you and the teacher or principal, or if you are dissatisfied with the school, answer No) If so, please explain: Yes No

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65. How many times in a usual week does your child need/get a spanking or other physical punishment? Yes No

66. Are you satisfied that your approach to discipline is working for your child? Yes No

This form helps track how well your child is doing:

Please complete for week of _____ (score for behavior over 7 days)

Child's Name: _____ Date completed: _____

Completed by: _____ Medication and dose: _____

Score each items as follows: 0 = Not True 1 = Somewhat or sometimes true 2 = Very or often true

1. Fails to finish things he/she starts	0	1	2
2. Can't concentrate, can't pay attention for long	0	1	2
3. Can't sit still, restless, or hyperactive	0	1	2
4. Fidgets	0	1	2
5. Daydreams or gets lost in his/her thoughts	0	1	2
6. Impulsive, or acts without thinking	0	1	2
7. Difficulty following directions	0	1	2
8. Talks out of turn	0	1	2
9. Messy	0	1	2
10. Inattentive, easily distracted	0	1	2
11. Talks too much	0	1	2
12. Fails to carry out assigned tasks	0	1	2
13. Headaches	0	1	2
14. Stomach aches	0	1	2
15. Poor appetite; not eating enough	0	1	2
16. Problems falling asleep	0	1	2
17. flat mood, as though a "zombie"	0	1	2
18. Irritable, easily made angry; or crying often	0	1	2
19. "Rebound" (behavior worse when medication wearing off)	0	1	2
20. Tics (rapid muscle twitches, not under child's control)	0	1	2

Notes:

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Classroom Goals Assessment

DATE: _____

CHILD'S NAME: _____

With your child's teacher, write in the goals you have for your child. Before each assessment meeting with your child's doctor, ask the teacher to rate how well your child has met each goal, in general, over the last few weeks. Add notes on the side, about how you and the teacher are working to help your child achieve each goal.

GOALS	NOT AT ALL	A LITTLE	PRETTY MUCH	VERY MUCH	NOTES
1. Able to wait his/her turn					
2. Able to handle frustration well					
3. Able to focus for entire period					
4. Able to complete assignments on time					
5. Able to cooperate with peers					
6. Able to follow class rules					