

History Form for ADHD Assessment

I. Developmental Factors

A. Prenatal History

1. How was your health during pregnancy?

Good Fair Poor Don't know _____

2. How old were you when your child was born?

Under 20 20-24 25-29 30-34 35-39 40-44 Over 44 Don't know _____

Do you recall using any of the following substances or medications during pregnancy?

3. Beer or wine

Never Once or twice 3-9 times 10-19 times 20-39 times 40+ times _____

4. Hard liquor

Never Once or twice 3-9 times 10-19 times 20-39 times 40+ times _____

5. Coffee or other caffeine (Cokes, etc.) Taken together, how many times?

Never Once or twice 3-9 times 10-19 times 20-39 times 40+ times _____

6. Cigarettes

Never Once or twice 3-9 times 10-19 times 20-39 times 40+ times _____

7. Street drugs

Never Once or twice 3-9 times 10-19 times 20-39 times 40+ times _____

8. Did you ingest any of the following substances?

Tranquilizers _____

Antiseizure medications (e.g. Dilantin) _____

Treatment for diabetes _____

Antibiotics (or antiviral medications) _____

Sleeping pills _____

Other (please specify) _____

B. Perinatal History

8. Did you have toxemia or eclampsia?

No Yes Don't know _____

9. Was there Rh factor incompatibility?

No Yes Don't know _____

10. Was (s)he born on schedule?

8 mos. or less 8-10 mos. 10 mos. Don't know _____

11. What was the duration of labor?

Under 6 hr. 7-12 hr. 12-18 hr. 19-24 hr. Over 24 hr. Don't know _____

12. Were you given any drugs to ease the pain during labor?

Name: _____

No Yes Don't know _____

13. Were there indications of fetal distress during labor or during birth?

No Yes Don't know _____

14. Was delivery:

Normal? No Yes _____

Breech? No Yes _____

Caesarian? No Yes _____

Forceps? No Yes _____

Induced? No Yes _____

15. What was the child's birth weight?

2 to 4 lb. 4 to 6 lb. 6 to 8 lb. 8 to 10 lb. 10 to 12 lb. Don't know _____

16. Were there any health complications following birth?

If yes, specify: _____

No

Yes

C. Postnatal Period and Infancy

17. Were there early infancy feeding problems?

No

Yes

18. Was the child colicky?

No

Yes

19. Were there early infancy sleep pattern difficulties?

No

Yes

20. Were there problems with the infant's responsiveness (alertness)?

No

Yes

21. Did the child experience any health problems during infancy?

Name: _____

No

Yes

22. Did the child have any congenital problems?

No

Yes

23. Was the child an easy baby? By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?

Very easy

Easy

Average

Difficult

Very diff.

24. How did the baby behave with other people?

More sociable than average

Average sociability

More unsociable than average

25. When (s)he wanted something, how insistent was (s)he?

Very

Pretty

Average

Not very

Not at all

26. How would you rate the activity level of the child as an infant/toddler?

Very

Active

Average

Less active

Not active

D. Developmental Milestones

27. At what age did (s)he sit up?

3-6 mos.

7-12 mos.

Over 12 mos.

Don't know

28. At what age did (s)he crawl?

3-6 mos.

7-12 mos.

Over 12 mos.

Don't know

29. At what age did (s)he walk?

Under 1 yr.

1-2 yr.

2-3 yr.

Don't know

30. At what age did (s)he speak single words (other than "mama" or "dada")?

9-13 mo

14-18 mo

19-24 mo

25-36 mo

37-48 mo.

Don't know

31. At what age did (s)he string two or more words together?

9-13 mo

14-18 mo

19-24 mo

25-36 mo

37-48 mo.

Don't know

32. At what age was (s)he toilet-trained? (bladder control)

Under 1 yr.

1-2 yr.

2-3 yr.

3-4 yr.

Don't know

33. At what age was (s)he toilet-trained? (bowel control)

Under 1 yr.

1-2 yr.

2-3 yr.

3-4 yr.

Don't know

34. Approximately how much time did toilet training take from onset to completion?

Under 1 mo.

1-2 mo

2-3 mo

Over 3 mo

II. Medical History

35. How would you describe his/her health?

Very good

Good

Fair

Poor

Very poor

36. How is his/her hearing?

Good

Fair

Poor

37. How is his/her vision?		Good	Fair	Poor	_____	
38. How is his/her gross motor coordination?		Good	Fair	Poor	_____	
39. How is his/her fine motor coordinations?		Good	Fair	Poor	_____	
40. How is his/her speech articulation?		Good	Fair	Poor	_____	
41. Has (s)he had any chronic health problems (e.g. asthma, diabetes, heart condition)?					_____	
	If yes, specify: _____		No	Yes	_____	
42. When was the onset of any chronic illness?					_____	
	Birth	0-1 yr.	1-2 yr.	2-3 yr.	3-4 yr.	Over 4 yr.
43. Which of the following illnesses has the child had?				No	Yes	_____
			Mumps	No	Yes	_____
			Chicken pox	No	Yes	_____
			Measles	No	Yes	_____
			Whooping cough	No	Yes	_____
			Scarlet fever	No	Yes	_____
			Pneumonia	No	Yes	_____
			Encephalitis	No	Yes	_____
			Otitis media	No	Yes	_____
			Lead poisoning	No	Yes	_____
			Seizures	No	Yes	_____
	Other diseases (specify): _____					_____
44. Has the child had any accidents resulting in the following?				No	Yes	_____
			Broken bones	No	Yes	_____
			Severe lacerations	No	Yes	_____
			Head injury	No	Yes	_____
			Severe bruises	No	Yes	_____
			Stomach pumped	No	Yes	_____
			Eye injury	No	Yes	_____
			Lost teeth	No	Yes	_____
			Sutures	No	Yes	_____
	Other (specify): _____					_____
45. How many accidents?						_____
	One	2-3	4-7	8-12	Over 12	_____
46. Has (s)he ever had surgery for any of the following conditions?				No	Yes	_____
			Tonsillitis	No	Yes	_____
			Adenoids	No	Yes	_____
			Hernia	No	Yes	_____
			Appendicitis	No	Yes	_____
			Eye, ear, nose, & throat	No	Yes	_____
			Digestive disorder	No	Yes	_____
			Urinary tract	No	Yes	_____
			Leg or arm	No	Yes	_____
			Burns	No	Yes	_____
	Other (specify): _____					_____
47. How many times?						_____
	One	Two	3-5	6-8	Over 8	_____

48. Duration of hospitalization?	One day	Day & night	2-3 days	4-6 days	1-4 weeks	1-2 months	Over 2 mos.	_____
49. Is there any suspicion of alcohol or drug use?					No	Yes	Don't know	_____
50. Is there any history of physical/sexual abuse?					No	Yes	Don't know	_____
51. Does the child have any problems sleeping?	None	Difficulty falling asleep		Sleep continuity disturbance		Early morning awakening		_____
52. Is the child a restless sleeper?					No	Yes	Don't know	_____
53. Does the child have bladder control problems at night?						No	Yes	_____
	If yes, how often?		_____					
	If yes, was (s)he ever continent?		_____					
	Does the child have bladder control problems during the day?		_____					
	If yes, how often?		_____			No	Yes	_____
	If yes, was (s)he ever continent?		_____					
54. Does the child have bowel control problems at night?						No	Yes	_____
	If yes, how often?		_____					
	If yes, was (s)he ever continent?		_____					
	Does the child have bowel control problems during the day?		_____					
	If yes, how often?		_____			No	Yes	_____
	If yes, was (s)he ever continent?		_____					
55. Does the child have any appetite control problems?						Overeats	Average	Undereats

III. Treatment History

56. Has the child ever been prescribed any of the following? (Note duration in months.)						No	Yes	_____
	If yes, duration:	_____	Ritalin			No	Yes	
	If yes, duration:	_____	Dexedrine			No	Yes	_____
	If yes, duration:	_____	Adderall			No	Yes	_____
	If yes, duration:	_____	Anticonvulsants			No	Yes	_____
	If yes, duration:	_____	Wellbutrin			No	Yes	_____
	If yes, duration:	_____	Strattera			No	Yes	_____
	If yes, duration:	_____	Other prescription drugs			No	Yes	_____
57. Has the child ever had any of the following forms of psychological treatment?						No	Yes	_____
	If yes, how long:	_____	Individual psychotherapy			No	Yes	
	If yes, how long:	_____	Group psychotherapy			No	Yes	_____
	If yes, how long:	_____	Family therapy with child			No	Yes	_____
	If yes, how long:	_____	Inpatient evaluation/Rx			No	Yes	_____
	If yes, how long:	_____	Residential treatment			No	Yes	_____

IV. School History

Please summarize the child's progress (e.g. academic, social, testing) within each of these grade levels:

Preschool:

Kindergarten:

Grades 1 through 3:

Grades 4 through 6:

Grades 7 through 12:

58. Has the child ever been in any type of special educational program?

If yes, how long: _____	Learning disabilities class	No	Yes	_____
If yes, how long: _____	Behavioral/emotional disorders class	No	Yes	_____
If yes, how long: _____	Resource room	No	Yes	_____
If yes, how long: _____	Speech & language therapy	No	Yes	_____
Other (specify): _____				

59. Has the child ever been?

If yes, how many times: _____	Suspended from school	No	Yes	_____
If yes, how many times: _____	Expelled from school	No	Yes	_____
If yes, how many times: _____	Retained in grade	No	Yes	_____

60. Have any additional instructional modifications been attempted?

None	Behavior modification program	Daily/weekly report card	Other, specify	_____
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V. Social History

61. How does the child get along with his/her brothers/sisters?

Doesn't have any	Better than average	Average	Worse than average	_____
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62. How easily does the child make friends?

Easier than average	Average	Worse than average	Don't know	_____
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63. On the average, how long does your child keep friendships?

Less than 6 months	6 months to 1 year	More than 1 year	Don't know	_____
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VI. Current Behavioral Concerns

Primary concerns

Other (related) concerns

64. What strategies have been implemented to address these problems? (Check which have been successful)

Verbal reprimands	_____
Time out (isolation)	_____
Removal of privileges	_____

	Rewards	_____
	Physical punishment	_____
	Acquiescence to child	_____
	Avoidance of child	_____
65. On the average, what percentage of the time does your child comply with initial commands?		
	0-20%	_____
	20-40%	_____
	40-60%	_____
	60-80%	_____
	80-100%	_____
66. On the average, what percentage of the time does your child eventually comply with commands?		
	0-20%	_____
	20-40%	_____
	40-60%	_____
	60-80%	_____
	80-100%	_____
67. To what extent are you and your spouse consistent with respect to disciplinary strategies?		
	Most of the time	_____
	Some of the time	_____
	None of the time	_____
68. Have any of the following stress events occurred within the past 12 months?		
	Parents divorced or separated	_____
	Family accident or illness	_____
	Death in family	_____
	Parent changed job	_____
	Changed schools	_____
	Family moved	_____
	Family financial problems	_____
	Other, specify	_____

VII. Diagnostic Criteria

69. Which of the following are considered to be a significant problem at the present time?

Fidgets	No	Yes	_____
Difficulty remaining seated	No	Yes	_____
Easily distracted	No	Yes	_____
Difficulty awaiting turn	No	Yes	_____
Often blurts out answers to questions before they have been completed	No	Yes	_____
Difficulty following instructions	No	Yes	_____
Difficulty sustaining attention	No	Yes	_____
Shifts from one activity to another	No	Yes	_____
Difficulty playing quietly	No	Yes	_____
Often talks excessively	No	Yes	_____
Often interrupts or intrudes on others	No	Yes	_____
Often does not listen	No	Yes	_____
Often loses things	No	Yes	_____
Often engages in physically dangerous activities	No	Yes	_____
		Total for ADHD (8 or more)	_____

70. When did these problems begin? (Specify age)

71. Which of the following are considered to be a significant problem at the present time?

Often loses temper	No	Yes	_____
Often argues with adults	No	Yes	_____
Often actively defies or refuses adult requests or rules	No	Yes	_____
Often deliberately does things that annoy other people	No	Yes	_____
Often blames others for own mistakes	No	Yes	_____
Is often touchy or easily annoyed by others	No	Yes	_____
Is often angry or resentful	No	Yes	_____
Is often spiteful or vindictive	No	Yes	_____
Often swears or uses obscene language	No	Yes	_____
Total for Oppositional Defiant Disorder (5 or more)			_____

72. When did these problems begin? (Specify age)

73. Which of the following are considered to be a significant problem at the present time?

Stolen without confrontation	No	Yes	_____
Run away from home overnight at least twice	No	Yes	_____
Lies often	No	Yes	_____
Deliberate fire-setting	No	Yes	_____
Often truant	No	Yes	_____
Breaking and entering	No	Yes	_____
Destroyed others' property	No	Yes	_____
Cruel to animals	No	Yes	_____
Forced someone else into sexual activity	No	Yes	_____
Used a weapon in a fight	No	Yes	_____
Often initiates physical fights	No	Yes	_____
Stolen with confrontation	No	Yes	_____
Physically cruel to people	No	Yes	_____
Total for Conduct Disorder (3 or more)			_____

74. When did these problems begin? (Specify age)

75. Which of the following are considered to be a significant problem at the present time?

Unrealistic and persistent worry about possible harm to attachment figures	No	Yes	_____
Unrealistic and persistent worry that a calamitous event will separate the child from attachment figure	No	Yes	_____
Persistent school refusal	No	Yes	_____
Persistent refusal to sleep alone	No	Yes	_____
Persistent avoidance of being alone	No	Yes	_____
Repeated nightmares re: separation	No	Yes	_____
Somatic complaints	No	Yes	_____
Excessive distress in anticipation of separation from attachment figure	No	Yes	_____
Excessive distress when separated from home or attachment figures	No	Yes	_____
Total for Separation Anxiety Disorder (3 or more)			_____

76. When did these problems begin? (Specify age)

77. Which of the following are considered to be a significant problem at the present time?

Unrealistic worry about future events	No	Yes	_____
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Unrealistic concern about appropriateness of past behavior	No	Yes	_____
Unrealistic concern about competence	No	Yes	_____
Somatic complaints	No	Yes	_____
Marked self-consciousness	No	Yes	_____
Excessive need for reassurance	No	Yes	_____
Marked inability to relax	No	Yes	_____

Total for Overanxious Disorder (4 or more)

78. When did these problems begin? (Specify age)

793 Which of the following are considered to be a significant problem at the present time?

Depressed or irritable mood most of day, nearly every day	No	Yes	_____
Diminished pleasure in activities	No	Yes	_____
Decrease or increase in appetite associated with possible failure to make weight gain	No	Yes	_____
Insomnia or hypersomnia nearly every day	No	Yes	_____
Psychomotor agitation or retardation	No	Yes	_____
Fatigue or loss of energy	No	Yes	_____
Feelings of worthlessness or excessive inappropriate guilt	No	Yes	_____
Diminished ability to concentrate	No	Yes	_____
Suicidal ideation or attempt	No	Yes	_____

Total for Major Depressive Episode (items 3-9) (5 or more)

80. When did these problems begin? (Specify age)

81. Which of the following are considered to be a significant problem at the present time?

Depressed or irritable mood for most of the day x 1 yr.	No	Yes	_____
Poor appetite or overeating	No	Yes	_____
Insomnia or hypersomnia	No	Yes	_____
Low energy or fatigue	No	Yes	_____
Low self-esteem	No	Yes	_____
Poor concentration or difficulty making decisions	No	Yes	_____
Feelings of hopelessness	No	Yes	_____
Never without symptoms for > 2 mos. over a one year period	No	Yes	_____

Total for Dysthymia (items 2-7) (3 or more)

82. When did these problems begin? (Specify age)

VIII. Other Concerns

83. Has the child exhibited any of the symptoms below?

Stereotyped mannerisms	No	Yes	_____
Odd postures	No	Yes	_____
Excessive reaction to noise or fails to react to loud noises	No	Yes	_____
Overreacts to touch	No	Yes	_____
Compulsive rituals	No	Yes	_____
Motor tics	No	Yes	_____
Vocal tics	No	Yes	_____

Total

NOTE: The remaining questions in this section are optional.

84. Has the child exhibited any symptoms of thought disturbance, including any of the following:				
	Loose thinking (e.g. tangential ideas, circumstantial speech)	No	Yes	_____
	Bizarre ideas (e.g. odd fascinations, delusions, hallucinations)	No	Yes	_____
	Disoriented, confused, staring, or "spacey"	No	Yes	_____
	Incoherent speech (mumbles, jargon)	No	Yes	_____
			Total	_____
85. Has the child exhibited any symptoms of affective disturbance, including any of the following:				
	Excessive lability without reference to environment	No	Yes	_____
	Explosive temper with minimal provocation	No	Yes	_____
	Excessive clinging, attachment, or dependence on adults	No	Yes	_____
	Unusual fears	No	Yes	_____
	Strange aversions	No	Yes	_____
	Panic attacks	No	Yes	_____
	Excessively constricted or bland affect	No	Yes	_____
	Situationally inappropriate emotions	No	Yes	_____
			Total	_____
86. Has the child exhibited any symptoms of social conduct disturbance, including the following:				
	Little of no interest in peers	No	Yes	_____
	Significantly indiscreet remarks	No	Yes	_____
	Initiates or terminates interactions inappropriately	No	Yes	_____
	Qualitatively abnormal social behavior	No	Yes	_____
	Excessive reaction to changes in routine	No	Yes	_____
	Abnormalities of speech	No	Yes	_____
	Self-mutilation	No	Yes	_____
			Total	_____

IX. Family History

87. How long have you and the child's father (mother) been married? Please note whether the child was the product of 1st, 2nd, etc. marriage.)	Never	Separated	Divorced	Widowed	Married for _____ years	_____
88. How stable is your current marriage?					Stable	Unstable

NOTES

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

<p>For Office Use Only</p> <p>Total Symptom Score for questions 1–18: _____</p> <p>Average Performance Score for questions 19–26: _____</p>
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Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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