Initial ADHD Evaluation Parent Questionnaire
(BLACK INK ONLY PLEASE)

Date: _____________________________

Name: ________________________________________________ DOB: ____________________  MRN: _________________

Teacher: ______________________________________________ Subject: _______________________________________

I. EDUCATION HISTORY  This section to be completed by Parents

School______________________________________________________________________Current Grade________________
Primary Teacher____________________________________________________Total # of Teachers____________________

What grade did school problems start?________________________________________________________________________

Is your child currently receiving additional help?     SSD________________ Other_____________________________________

Has your child had educational testing?     No____ Yes____ If yes, by whom?_________________________________________

Results of testing_________________________________________________________________________________________

Other problems___________________________________________________________________________________________

Areas of concern:
___absenteeism         ___peer relations        ___memory                ___written expression     ___classwork completion
___anger control        ___risk taking                 ___motor skills                ___attention                   ___homework
___disobedience       ___self esteem                 ___reading                ___distractibility             ___health problems
___disruptive behavior        ___unhappy @ school            ___receptive language       ___hyperactivity            ___inconsistent performance
___immaturity     ___expressive language   ___retaining information                                           ___test taking
___motivation      ___math   ___spelling

Comments on items __________________________________________________________________________________________________

___________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________

II. PAST MEDICAL HISTORY / REVIEW OF SYSTEMS  This section to be completed by Parents

1. Does the patient have any ongoing medical problems? Y   N

2. Do you have concerns about diet, sleep, exercise? Y   N

3. Has the patient had any of the following conditions:

surgical procedures, significant allergies or allergic reactions to medications, head injury, seizures, facial tics or other repeated body movements, meningitis encephalitis or poisoning of any type? Y   N

4. Has the patient had any of the following problems:

bed wetting, stool soiling, temper outbursts, mood changes, anxiety, depression, getting along with peers, lying, stealing, fire setting, destructiveness, cruelty to animals or self injury? Y   N

5. Did the mother have any medical problems during pregnancy, labor, delivery or post delivery period? Y   N

6. Did the patient have difficulty breathing or crying after delivery, have poor color, poor suck, slow growth and development? Y   N

7. Is the patient taking any medication at present? Y   N

If yes, list medications:

8. Has your child been evaluated by an MD or mental health professional in the past for school or attentional problems? Y   N

If Yes to any of the above please comment

___________________________________________________________________________________________________________________

___________________________________________________________________________________________________________________

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rev 3/08
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III. SOCIAL / FAMILY HISTORY  This section to be completed by Parents

Mother’s name____________________________________________Father’s name____________________________________
Occupation_______________________________________________Occupation______________________________________
Parents: Married________ Divorced________ Separated________
Patient lives with:_________________________________________________________________________________________
Siblings – names and ages:__________________________________________________________________________________
_______________________________________________________________________________________________________

Is there a family history of Attention Deficit Disorder, depression or substance abuse?     Yes ☐     No ☐
If Yes please comment_____________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

IV. VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE  This section to be completed by Parents

Please circle the frequency code which best describes your child in the context of what is appropriate for his/her age.

Frequency Code: 0 = Never  1 = Occasionally  2 = Often  3 = Very Often

1.  Does not pay attention to details or makes careless mistakes, for example homework  0     1     2     3
2.  Has difficulty sustaining attention to tasks or activities     0     1     2     3
3.  Does not seem to listen when spoken to directly      0     1     2     3
4.  Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)  0     1     2     3
5.  Has difficulty organizing tasks and activities 0     1     2     3
6.  Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort 0     1     2     3
7.  Loses thing necessary for tasks or activities (school assignments, pencils, or books) 0     1     2     3
8.  Is easily distracted by extraneous 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 excessively in situations in which remaining seated is expected 0     1     2     3
13. Has difficulty playing or engaging in leisure/play activities quietly 0     1     2     3
14. Is “on the go” or often acts as if “driven by a motor” 0     1     2     3
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15. Talks too much 0 1 2 3
16. Blurs out answers before questions have been completed 0 1 2 3
17. Has difficulty waiting his/her turn 0 1 2 3
18. Interrupts or intrudes on others (e.g., butts into conversations or games) 0 1 2 3
19. Argues with adults 0 1 2 3
20. Loses temper 0 1 2 3
21. Actively defies or refuses to comply with adults’ requests or rules 0 1 2 3
22. Deliberately annoys people 0 1 2 3
23. Blames others for his or her mistakes or misbehaviors 0 1 2 3
24. Is touchy or easily annoyed by others 0 1 2 3
25. Is angry or resentful 0 1 2 3
26. Is spiteful and vindictive 0 1 2 3
27. Bullies, threatens, or intimidates others 0 1 2 3
28. Initiates physical fights 0 1 2 3
29. Lies to obtain goods for favors or to avoid obligations (i.e., “cons” others) 0 1 2 3
30. Is truant from school (skips school) without permission 0 1 2 3
31. Is physically cruel to people 0 1 2 3
32. Has stolen items of nontrivial value 0 1 2 3
33. Deliberately destroys others’ property 0 1 2 3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun) 0 1 2 3
35. Is physically cruel to animals 0 1 2 3
36. Has deliberately set fires to cause damage 0 1 2 3
37. Has broken into someone else’s home, business, or car 0 1 2 3
38. Has stayed out at night without permission 0 1 2 3
39. Has run away from home overnight 0 1 2 3
40. Has forced someone into sexual activity 0 1 2 3
41. Is fearful, anxious, or worried 0 1 2 3
42. Is afraid to try new things for fear of making mistakes 0 1 2 3
43. Feels worthless or inferior 0 1 2 3
44. Blames self for problems, feels guilty 0 1 2 3
45. Feels lonely, unwanted, or unloved: complains that “no one loves him/her” 0 1 2 3
46. Is sad, unhappy, or depressed 0 1 2 3
47. Is self-conscious or easily embarrassed 0 1 2 3
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Date: _____________________________

Name: ________________________________________________ DOB: ____________________  MRN: _________________

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PERFORMANCE

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<th>Problematic</th>
<th>Average</th>
<th>Above Average</th>
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<td></td>
</tr>
<tr>
<td>a. Reading</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>b. Mathematics</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>c. Written Expression</td>
<td>1 2 3 4 5</td>
<td></td>
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<td>2. Overall Classroom Performance</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>a. Relationship with Peers</td>
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<td></td>
</tr>
<tr>
<td>b. Following Directions/Rules</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>c. Disrupting Class</td>
<td>1 2 3 4 5</td>
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<td>d. Assignment Completion</td>
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<tr>
<td>e. Organizational Skills</td>
<td>1 2 3 4 5</td>
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</table>

Please include any observations you feel are pertinent: __________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Return form to your pediatrician when complete.