Initial ADD Evaluation Form

Date of Evaluation _____

Patient Name _____ Date of Birth _____ Current age _____ Grade _____

Information provided by: _____ Relation to patient _____

Teacher Name(s) _____ School _____ Phone #(s) _____

Teacher Name(s) _____ School _____ Phone #(s) _____

Past Medical History

Complications of pregnancy	Y N	Any developmental concerns	Y N	Hx of seizures	Y N
Complications of delivery	Y N	Hearing problems	Y N	Hx of abnormality of the heart	Y N
Premature birth > 6 weeks	Y N	Significant past head injury	Y N	Hx of a heart murmrur	Y N
Problems during nursery stay	Y N	Serious illness/hospitalization	Y N	Hx of heart skipping beats	Y N
Walked by 18 Months	Y N	Chronic illness	Y N	Hx of any heart tests	Y N
Talked by 18 months	Y N	Possible lead exposure	Y N	Hx of fainting or passing out	Y N

Please explain details of any yes question: _____

_____

_____

_____

_____

Family History (Include blood relatives only)

ADD / ADHD	Y N	Thyroid disease	Y N
Bipolar disorder	Y N	Heart arrhythmias	Y N
Opposition/Defiant disorder	Y N	Relatives with a pacemaker	Y N
Any other neuropsychiatric disorder	Y N	Sudden unexplained death	Y N
Alcohol/drug addiction or abuse	Y N	Heart problems < age 40	Y N
Seizure disorder	Y N		

Please explain details of any yes question including relationship to patient: _____

_____

_____

_____

_____

Social History

Does the patient currently live with both biological parents? Y N. If yes, are they married? Y N. Both living? Y N.

If no, please describe the living arrangements, including any shared custody arrangements if applicable:

_____

_____.

Who is/are the patient's primary caretaker(s)_____.

Relationship(s) to Patient _____.

Are there currently any major family stressors? _____.

Do any household members or close family contacts to the patient have a history of drug abuse? Y N