C A M E L B A C K P E D I A T R I C S , P.C.

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Patient Name: ________________________________ **DOB:** ______________

Attention Deficit Disorder
Initial Intake

Some of these questions may have been positive when your child was younger. If so please, mark yes.

1. At what age was ADD first suspected?
2. Has there ever been a previous diagnosis of attention deficit disorder by a physician or a psychologist?
   a. If so, by whom?
   b. If so, when?
   c. Has there ever been previous treatment?
3. Where does your child go to school?
4. What grade is your child in?
5. What were the grades on the last report card? Please be a specific as possible.
6. Do you feel your child talk excessively?
7. Do you feel your child had difficulty engaging in quiet play?
8. Do you feel your child interrupts others too much?
9. Does your child blurt out an answer before a question is completed?
10. Do you feel your child has difficulty awaiting turns?
11. Does your child leave his/her seat when inappropriate?
12. Does your child have a hard times sitting still? (always on the go, squirms in seat, fidgets with hands or feet)

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13. Does your child have difficulty making or keeping friends?
14. Is your child easily distracted by extraneous stimuli?
15. Does your child often lose or misplace things?
16. Does your child forget to turn in homework?
17. Does your child often seem to pay no attention when spoken to?
18. Does your child have difficulty sustaining attention in tasks or play?
19. Does your child dislike or avoid activities that require sustained mental effort?
20. Does your child require the “homework police” (parents need to be present to get homework done)?
21. Does your child have difficulty with organization?
22. Does your child have difficulty following instructions or finishing work?
23. Is your child often forgetful in daily activates?
24. Does your child fail to pay close attention or makes careless mistakes?
25. Is there a family history of attention deficit disorder?
26. Is there a family history of anxiety or obsessive compulsive disorder (ocd)?
27. Is there a family history of depression?
28. Is there a family history of alcoholism?
29. Is there a family history of substance abuse?
30. Does your child have any general health issues?
31. Was your child premature?
32. Are there any vision issues that you are aware of?
33. Are there any hearing issues that you are aware of?
34. Does your child seem well rested when he awakens?

35. Does your child snore loudly and pause breathing while asleep?
36. Is there anyone in the family under 50 years of age who has collapsed while exercising, has a pacemaker or takes anti-arrhythmia heart rate medicines?
37. Has your child ever had speech therapy, occupational therapy, or physical therapy?
38. Has there ever been a concern about delayed developmental milestones?
39. Has there been any brain issues such as concussions, seizures or brain infections?
40. Does your child have motor tics or is there a family history of motor tic?
41. Do you feel your child is anxious?
42. Does your child worry excessively about school, family, and health issues?
43. Has your child ever avoided going to school or going to unfamiliar environments?
44. Have you ever felt your child was depressed?
45. Does your child seem sad, hopeless, or withdrawn?
46. Does your child seem fatigued and without energy?
47. Does your child look forward to events with family and friends?
48. Does your child frequently argue with you?
49. Does your child sometimes “lose control” when angry or arguing?