Nova Wellness Center
CLINIC & MEDSPA

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Intake Questionnaire for ADD/ADHD Assessment

For patients who are younger than 18 years of age.

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

PATIENT IDENTIFICATION: Today's Date:_____

Name: _____

Date of Birth: _____Age: _____ Sex _____

Name of the person completing this form:_____

Relationship to the patient:_____

How did you hear about our office?_____

Has the patient been evaluated by a medical or mental health professional for the diagnosis Of attention deficit disorder previously? If so, please elaborate-

_____

_____

_____

What are your goals in seeking this consultation? What do you hope to gain?

_____

_____

_____

_____

FAMILY STRUCTURE/HISTORY:

Who does the patient currently live with?

_____

Natural Mother's History- Age: _____ Employed as: _____

School- highest grade completed: _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages: _____

Has mother ever sought psychiatric treatment? Yes _____ No _____

If yes, for what purpose? _____

_____

Mother's alcohol/drug use history: _____

Natural Father's History- Age: _____ Employed as: _____

School- highest grade completed: _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages: _____

Has father ever sought psychiatric treatment? Yes _____ No _____

If yes, for what purpose? _____

_____

Father's alcohol/drug use history: _____

Siblings (names, ages, relationship to patient, medical problems, academic success or problems, history of substance abuse or criminal activity)

_____

_____

_____

EDUCATIONAL HISTORY:

Last grade completed or currently enrolled in: _____

Last school attended or school currently attending: _____

Average grades received: _____

Any academic problems: _____

Learning strengths: _____

Any behavior problems in school? _____

Elementary, Intermediate and High School: (please check all that apply)

_____ Special education classes

_____ Resource classes

_____ Tutoring provided by the school

_____ Repeated a grade level: level(s) repeated:_____ voluntary_____ mandated _____

_____ Attended summer school: number of summers attended _____

_____ Advanced placement (tested out of classes or a grade level)

_____ Pre-AP classes

_____ AP classes

_____ Dual credit classes (received both high school and college credits)

_____ Gifted and talented classes or curriculum

_____ Alternative school or curriculum

_____ Charter school attendance

_____ Private school attendance

_____ Homeschool attendance

High School: Received diploma:_____ Received GED:_____ Dropped out in the _____ Grade

MEDICAL HISTORY: (please mark all conditions that apply)	CURRENTLY EXPERIENCING	EXPERIENCED IN THE PAST	FAMILY HISTORY
Attention deficit disorder (ADD or ADHD)			
Seasonal allergies			
Asthma			
Eczema			
Recurrent headaches			
Seizures/convulsions			
Gastrointestinal problems			
Food intolerance			
Cardiac problems			
Restless legs syndrome (RLS)			
Thyroid disorder			
Sleep apnea			
Insomnia			
Vitamin deficiency			
Premenstrual syndrome (PMS)			
Menopausal symptoms			
Irregular menstrual cycles			
Testosterone deficiency			
Dyslexia			
Vision problems			
Hearing problems			
Depression			
Anxiety			
Vision problems			
Schizophrenia			
Anger disorder			
Conduct disorder			
Oppositional defiant disorder			
Bipolar disorder			

CURRENT LIFE STRESSES:

(Include anything that is currently stressful for the patient or the patient's family. Examples include relationship, job, school, finances, children or siblings, marriages, separations, divorces, death, traumatic event, losses, abuse, etc.)

_____

_____

_____

_____

PAST TREATMENTS:
Please list any prescription medications, supplements or other treatments that have been tried to improve attention and/or decrease hyperactivity. Include as much detail as possible including whether or not the treatment helped and any side effects or problems experienced with the treatment. Are the treatments still being used? If not, why were they stopped?

_____
_____
_____
_____
_____

PREVIOUS PROVIDERS:
Please list any physicians, mental health providers, counselors, therapists or life coaches that are currently being used or were used in the past. If there were problems with previous providers, including their office staff or policies please describe them below.

_____
_____
_____
_____

INFANCY
Were any of the following problems present during your child's first few years of life:
(Circle one answer for each question)

Did not enjoy cuddling	Yes	No
Difficult to comfort	Yes	No
Colic	Yes	No
Excessive restlessness	Yes	No
Excessive irritability	Yes	No
Excessive crying	Yes	No
Excessive shyness	Yes	No

Did your child seem to develop more slowly than other children in the following areas: (Circle one answer for each question)

Walking	Yes	No
Talking	Yes	No
Riding a bike	Yes	No
Learning to skip	Yes	No
Learning to throw or catch	Yes	No

Birth weight: _____

Did your child have a difficult or premature birth?

_____
_____
_____

TEMPERAMENT/MOOD

Did your child, as a youngster or teen, at any time, display/experience severe mood shifts or seem significantly depressed, irritable, violent, or super-energized? Please describe in detail.

_____
_____
_____
_____
_____

Did you ever notice that your child would talk *too* much or *too* loudly, or would talk quickly, shifting from topic to topic and not be able to be redirected? Please describe the intensity and how often it would occur. _____
_____
_____
_____

Did your child engage in dangerous or risky behavior, often make poor judgments, or act impulsively? Please describe. _____
_____
_____
_____

Did your child ever experience visual or auditory hallucinations, severe thought distortion, or tyrannical behavior? Was your child oppositional? _____
_____

Would your child become more active in the evening; becoming troublesome or having 'fits'? Did your child have nightmares or night terrors, trouble sleeping, insomnia? How was your child in the morning upon waking? Please describe. _____

_____

_____

Did your child seem more 'cruel' than other children or have more trouble than other children in understanding the feelings of others?

_____

_____

SCHOOL HISTORY

Please indicate whether your child had any of the following school experience (circle one answer for each question).

Was retained a grade in school-	**Yes**	**No**
Difficulty with reading -	**Yes**	**No**
Difficulty with math-	**Yes**	**No**
Received poor grades-	**Yes**	**No**
Disliked doing homework-	**Yes**	**No**
Disliked going to school-	**Yes**	**No**
Had behavior problems in school-	**Yes**	**No**
Was tested for special education-	**Yes**	**No**

If **yes** to any of the above, please describe the problems.

_____

_____

_____

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CHILDHOOD ADHD RATING SCALE- to be completed by the patient's parent if they are 5 to 12 years of age.

		Not at all	Just a little	Pretty Much	Very Much
1.	Often failed to give close attention to details or made careless mistakes	0	1	2	3
2.	Had difficulty sustaining attention in tasks or activities	0	1	2	3
3.	Often did not seem to listen	0	1	2	3
4.	Did not follow through in instructions and failed to finish school work and chores	0	1	2	3
5.	Often had difficulty organizing tasks and activities	0	1	2	3
6.	Often avoided or disliked doing schoolwork or homework	0	1	2	3
7.	Often lost or misplaced things (i.e. toys, school assignments, books, pencils, etc.)	0	1	2	3
8.	Was easily distracted	0	1	2	3
9.	Was often forgetful	0	1	2	3
10.	Was often fidgety or squirming in seat	0	1	2	3
11.	Had difficulty remaining seated	0	1	2	3
12.	Often ran about and climbed excessively in inappropriate situations	0	1	2	3
13.	Often had difficult playing quietly	0	1	2	3
14.	Often "on the go" or acted if driven by a motor	0	1	2	3
15.	Often talked excessively	0	1	2	3
16.	Often blurted out answers before questions had been completed	0	1	2	3
17.	Had difficulty awaiting turn	0	1	2	3
18.	Often interrupted or intruded on others (i.e. butted into conversations or games)	0	1	2	3

CHECKLIST FOR YOUR UPCOMING APPOINTMENT:

____Please bring this information packet with you to your appointment.

____Please remember to bring all medications and supplements with you to your appointment.

____Please bring any progress notes, report cards, teacher communications that you feel are pertinent for your child's evaluation

____Please bring any employment related information that you believe is pertinent to your evaluation.

____Please be ready to provide the names, addresses and phone numbers of any medical providers who have previously evaluated or treated the patient. You will need this information to complete our *Request for Records Release* form.

____Please confirm your appointment date and time. Visit our website to make sure you know how to locate our office. Plan to arrive 15 minutes early to your appointment. **Your first visit to our office will likely take 1-2 hours total, please allow enough time in your schedule for this.**