

Northwest Pediatrics Supplemental ADD Information

Date: _____

Child's name _____ DOB _____

Parent's name _____ Phone # _____

Patient's Education History:

School _____ current grade _____

What grade did school problems start? _____

Is your child currently receiving additional help? _____ SSD? _____ Other? _____

Has your child had educational/psychological testing? _____ If yes, by whom? _____

Results of Testing? _____

Areas of Concern:

<input type="checkbox"/> absenteeism	<input type="checkbox"/> peer relations	<input type="checkbox"/> memory	<input type="checkbox"/> written expression	<input type="checkbox"/> classwork completion
<input type="checkbox"/> anger control	<input type="checkbox"/> risk taking	<input type="checkbox"/> motor skills	<input type="checkbox"/> attention	<input type="checkbox"/> homework
<input type="checkbox"/> disobedience	<input type="checkbox"/> self esteem	<input type="checkbox"/> reading	<input type="checkbox"/> distractibility	<input type="checkbox"/> health problems
<input type="checkbox"/> disruptive behavior	<input type="checkbox"/> unhappy	<input type="checkbox"/> receptive language	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> anxious
<input type="checkbox"/> motivation	<input type="checkbox"/> immaturity	<input type="checkbox"/> expressive language	<input type="checkbox"/> retaining information	
<input type="checkbox"/> test taking	<input type="checkbox"/> math	<input type="checkbox"/> spelling	<input type="checkbox"/> inconsistent performance	

Comments: _____

Social/Family History:

Mother's name _____ Father's name _____

Occupation _____ Occupation _____

Parents are: Married _____ Divorced _____ Separated _____

Patient lives with: _____

Siblings (names and ages): _____

Is there a family history of attention problems, depression, other psychiatric problems, or substance abuse? _____ If yes, please comment _____