Dear Parents,

Your child is being evaluated for attention, school, or behavioral problems. As part of this evaluation, we are asking that you:

STEP ONE:

Complete the parent forms.

Complete the registration form, and

STEP TWO:

Give the school forms to your child's teacher.

- If your child has more than one academic teacher, please make sure TWO Academic teachers fill out the packet (you or the school can copy the forms.)
- **If your child is on summer break or not enrolled in school, you may:**
  Wait until school resumes, or
  Have a camp counselor, babysitter, etc. fill out the forms.

Collect the forms from your child's teacher.

STEP THREE:

SCHEDULE AN APPOINTMENT with your child's doctor once you have completed and collected the parent AND teacher forms.

Thank you for your concern and commitment to helping your child. We look forward to working with you.

Form No. 21

CHILD REGISTRATION FORM FOR PARENTS

PLEASE PRINT

Child's Name:	**Sex: M F**	**Date of Birth:**
Child's Mailing Address:	City:	State/ZIP:
Home Phone, with area code: ( )	Child's Insurance	
Child's Social Security Number:	Child's Race/Ethnicity:	

Child's Legal Guardian (please circle): Mother Father Both Other (specify)

Mother's Name:	**Date of Birth:**	**Home Phone: ( )**
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

Father's Name:	Date of Birth:	Home Phone: ( )
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

If there is another guardian other than the parents of this child, please complete guardian information below:

Guardian's Name:	Date of Birth:	Home Phone: ( )
Relationship to child:	Marital Status: S M W D Sep	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

PARENTS: Before we can evaluate your child, we need to collect information from your child's medical records, school, and other professionals involved in your child's care. We need your permission to do this. Please sign below.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Signature______________________________ Date____________________

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PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First):	Date of Birth:	Age:	Sex: M F	Today's Date:
Address: City:	State:	Zip:		Phone:

Child's Race (circle): 8=Don't Know 2=Black or African American 3=White 4=Asian or Pacific Islander 5=American Indian / Alaskan Native 6=Other, specify: ____________________

Is your child also Hispanic or Latino (circle): Yes No	Child's Doctor:	Doctor's Phone:
Name of person completing this form:	Relationship to child:	Phone:

CHIEF CONCERN:

1. Who suggested this child be seen by the doctor for attention, school, or behavior problems:

2. What **concerns** do you have about your child?
a.
b.
c.

3. How long have you been concerned about this child's behavior?	**4.** Please circle ONE: Overall, the above concerns are **mild**, **moderate**, or **severe**?	**5.** Please circle ONE: My concerns are **improving, staying the same,** or **getting worse**?

6. Please describe this child's **strongest areas at home:**
a.
b.
c.

7. Please describe this child's **weakest areas at home:**
a.
b.
c.

HISTORY: Birth

1. How much did this child weigh at birth? ____ pounds ____ ounces

2. Biological **Father's age** at birth of this child: ________

3. Biological **Mothers's age** at birth of this child: ________

4. Number of pregnancies prior to this child: ________

5. Number of miscarriages prior to this child: ________

Y	**N**	**6.** Were there any **problems during this pregnancy**? Specify:
Y	**N**	**7.** Were there any **problems during labor / delivery** or **following the birth**? Specify:
Y	**N**	**8.** Was this child born by **Cesarean / C-Section**? If yes, circle appropriate response: **planned** **emergency**
Y	**N**	**9.** Was this child born **two or more weeks before** the "due date"? If yes, how many weeks early was this child? __________ weeks
Y	**N**	**10.** Were any substances or **medications used by the mother** during the pregnancy? —— Beer / Wine ______ Alcohol ______ Any prescription medication ______ Cocaine —— Tobacco ______ Marijuana ______ Methamphetamine (Crystal / Ice) ______ Other:____________
Y	**N**	**10.** Were any substances or **medications used by the father** around the time this child was conceived? —— Beer / Wine ______ Alcohol ______ Any prescription medication ______ Cocaine —— Tobacco ______ Marijuana ______ Methamphetamine (Crystal / Ice) ______ Other:____________

*HISTORY: Developmental concerns

Y	*N*	**1.** Did this child **sit up** by 8 months?
Y	*N*	**2.** Did this child **crawl** by 10 months?
Y	*N*	**3.** Did this child **walk** by 15 months?
Y	*N*	**4.** Did this child **speak 2 word sentences** by 2 years?
Y	*N*	**5.** Could strangers **understand** this child by 3 years?
Y	*N*	**6.** Did this child **stay dry during the day** by 3 1/2 years?
Y	*N*	**7.** Did this child **read simple words** by 6 years?

(OFFICE USE ONLY) Y=[concern ≥ 6 months: Y N Birth: Y N] *N=[Development: Y N]

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PARENT QUESTIONNAIRE: Child Health *(continued)*

Child's Name:

HISTORY: Behavioral

Y	N	**1.** Did this child **cry frequently** as an infant?
Y	N	**2.** Was this child **difficult to calm** down as an infant?
Y	N	**3.** Did this child **have trouble sleeping** as an infant (e.g., was this child figety or overly sleepy)?
Y	N	**4.** Was this child a **picky or irregular eater** as an infant?
Y	N	**5.** Did this child **have many temper tantrums** as a toddler?
Y	N	**6.** Did you have **trouble keeping a babysitter** because of this child's behavior?
Y	N	**7.** Does this child have **urine accidents**?
Y	N	**8.** Does this child have **stool / bowel accidents**?
Y	N	**9.** Does this child often have **nightmares**?
Y	N	**10.** Has this child ever had **tics or nervous twitches,** such as repeated eye blinking, head jerking, or throat clearing?
Y	N	**11.** Does this child have any **problems falling asleep**? Specify:
Y	N	**12.** Does this child have any **problems staying asleep** through the night? Specify:
Y	N	**13.** Does this child have **problems getting up** in the morning? Specify:
Y	N	**14.** Does this child have **frequent stomachaches and headaches**? Specify:
Y	N	**15.** Does this child have **problems with his/her weight**? Specify:

HISTORY: Health

Y	N	**1.** Has this child had any **major health problems**? Specify:
Y	N	**2.** Has this child had frequent **ear infections**?
Y	N	**3.** Has this child had any **vision / eye or hearing** problems? Specify:
Y	N	**4.** Has this child ever been **hospitalized** or had **surgery**? Specify:
Y	N	**5.** Has this child lost **consciousness** or had a **serious head injury**? Specify:
Y	N	**6.** Has this child had **meningitis** or **encephalitis**? Specify:
Y	N	**7.** Has this child had **seizures**?
Y	N	**8.** Has this child had any **difficulties with growth**? Specify:
Y	N	**9.** Does this child have any **birth defects** or **birthmarks**? Specify:

HISTORY: Family Medical Problems: Is there anyone in this child's family with the following:				If yes, how is this person related to this child?
Y	N	DON'T KNOW	**1.** Neurologic problems	
Y	N	DON'T KNOW	**2.** Learning or reading difficulty	
Y	N	DON'T KNOW	**3.** Depression	
Y	N	DON'T KNOW	**4.** Bipolar Disorder / Manic Depression	
Y	N	DON'T KNOW	**5.** Schizophrenia	
Y	N	DON'T KNOW	**6.** History of physical or sexual abuse	
Y	N	DON'T KNOW	**7.** Alcohol or Drug problems	
Y	N	DON'T KNOW	**8.** ADHD / ADD (attention problems)	
Y	N	DON'T KNOW	**9.** Tics or Tourette's disorder	
Y	N	DON'T KNOW	**10.** Trouble with the law	
Y	N	DON'T KNOW	**11.** Medications for nerves or emotional problems	
Y	N	DON'T KNOW	**12.** Thyroid problems	
Y	N	DON'T KNOW	**13.** Exposure to toxic chemicals	
Y	N	DON'T KNOW	**14.** Cardiac problems or sudden death?	

(OFFICE USE ONLY) **Behavior:** Y N **Health:** Y N **Family Medical History:** Y N

Baseline: **Tics:** Y N **Sleep Problems:** Y N **Stomachache/Headache:** Y N **Weight:** Y N

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PARENT QUESTIONNAIRE: Child Information

Child's Name:

HISTORY: Child's Past/Current Treatment

Y	N	**1.** Has this child **ever been diagnosed with ADHD or ADD in the past**? If yes: Year ______ Month ______
Y	N	**2.** Has this child **ever taken medication for ADHD or ADD in the past**? If yes, do you know the name, dose, and time(s) of day the medication was given?

a. Name	Dose	Time(s) of Day)
b.		

c. Were you **satisfied** with the medication's effect on this child's symptoms? (circle) Yes No

Y	N	**3.** Has this child **ever received psychological counseling** for any problems? Specify:
Y	N	**4.** Has this child ever been on any **long-term medications**? Specify:
Y	N	**5.** Does this child have any **allergies**? Specify:
Y	N	**6.** Is this child currently taking any **medications**?
Y	N	**7.** Is this child currently taking any **vitamins or herbal supplements**?

8. What medication(s), including vitamins or herbal supplements, is this child currently taking?

Name	Dose	Time(s) of Day
a.		
b.		
c.		

9. Are there any professionals (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, or alternative treatments) **currently involved in this child's care? Please list them and their role in your child's care:**

HISTORY: Social

Y	N	**1.** Have there been any **major changes or stresses** in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet? If yes, please specify and include how old the child was at the time: Is this stress still occuring? (circle) Yes No
Y	N	**2.** Has there been a **serious illness or death** in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
Y	N	**3.** Has this child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occuring? (circle) Yes No
Y	N	**4.** Are there any **major changes or stresses** expected in the future? If yes, please specify:

(OFFICE USE ONLY) **Adhd Dx:** Y N **Adhd Tx:** Y N **Medications:** Y N **Professionals:** Y N **Socials:** Y N

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PARENT QUESTIONNAIRE: Child Information *(continued)*

Child's Name:

HISTORY: Child's Living Arrangement

1. This child is currently living with (please check one)

☐ Biological mother and biological father
☐ Biological mother
☐ Biological father
☐ Relative (specify relationship):
☐ Adoptive parent(s), relative
Does this child know that he / she is adopted? (circle) Yes No
☐ Adoptive parent(s), non-relative
Does this child know that he / she is adopted? (circle) Yes No
☐ Foster parent(s)
How long has this child been in foster care? Year ______ Month ______
How long has this child been living in your household? Year ______ Month ______
☐ Other (specify):

2. The **biological** parents of this child are currently (please check one):

☐ Married to each other Year ______ Month ______
☐ Divorced from each other Year ______ Month ______
☐ Separated from each other Year ______ Month ______
☐ Never married to each other
☐ Other (please specify):
☐ Not Applicable (please specify):
☐ Don't Know

3. How would describe the **current relationship** between this child's **biological parents**:

☐ Friendly / Amicable
☐ Unfriendly / Conflict ridden
☐ No relationship
☐ Not Applicable (please specify):
☐ Don't Know

Y	N	**4.** Are there any **immediate family members** who do not live with this child (biological mother, biological father, or siblings)? If yes, please specify relationship to child:
Y	N	**5.** Is there anything unusual about this child's **living arrangement** that you would like to discuss with the child's doctor? If yes, please specify:
Y	N	**6.** Are the parent(s)/guardian(s) of this child **working outside of the home**?
Y	N	**7.** Do you have family or social **support** locally?

8. Please list all people who are currently living in this child's household.

Name	Relationship to Child	Age	Name	Relationship to Child	Age

HISTORY: Military Family

Y	N	**1.** Are you or another parent/guardian of your child currently in the Military?
Y	N	**2.** What Branch: Navy Marine Air Force Army Other (specify):
Y	N	**3.** Are any of this child's parent(s)/guardian(s) Active Duty Military? If yes, who (circle): Mother Father Both Other:
Y	N	**4.** Are they deployed or deployable?
		5. When did you PCS / Move to this Location? Date:
		6. When are you due to PCS / Move? Date:
Y	N	**7.** Do you live in military housing?
Y	N	**8.** Is this child or other members of this family in the Exceptional Family Member Program?

(OFFICE USE ONLY) Living Arrangement: Y N

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PARENT QUESTIONNAIRE: Child Behavior

Child's Name:

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking mediction, please rate your child's behavior NOT on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very Often 3**
1. Fails to give close attention to detail or **makes careless mistakes** (e.g., homework).				
2. Has **difficulty attending** to what needs to be done.				
3. Does not seem to listen when spoken to directly.				
4. Does not follow through when given directions.				
5. Has difficulties organizing tasks and activities.				
6. Avoids, dislikes, or does not want to start tasks.				
7. Loses things necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by noises or other things.				
9. Is **forgetful** in daily activities.				
10. Fidgets with hands or feet or squirms in seat.				
11. Leaves seat when he/she is supposed to stay in seat.				
12. Runs about or climbs too much when he/she is supposed to stay seated.				
13. Has **difficulty playing** or starting quiet games.				
14. Is **"on the go"** or acts as if "driven by a motor".				
15. Talks too much.				
16. Blurts out answers before questions have been completed.				
17. Has **difficulty waiting his/her turn.**				
18. Interrupts or bothers others when they are talking or playing games.				
19. Argues with adults.				
20. Loses temper.				
21. Actively **disobeys** or **refuses** to follow adult's request or rules.				
22. Bothers people on purpose.				
23. Blames others for his or her mistakes or misbehaviors.				
24. Is **touchy or easily annoyed** by others.				
25. Is **angry or bitter**.				
26. Is **hateful** and wants to get even.				
27. Bullies, threatens, or scares others.				
28. Starts physical fights.				
29. Lies to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. Skips school without permission.				
31. Is **physically unkind** to people.				
32. Has **stolen things** that have value.				
33. Destroys others' property on purpose.				

(OFFICE USE ONLY) 1—9: ____/ 9 Inattentive: □≥ 6 / 9 DuPaul: 10—18: ____/ 9 Hyperactive: ≥ 6 / 9 DuPaul: 19—26: ____/ 8 Oppositional Defiant Disorder: ≥ 4 / 8

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PARENT QUESTIONNAIRE: Child Behavior *(continued)*

Child's Name:

Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking mediction, please rate your child's behavior NOT on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very Often 3**
34. Is physically **mean to animals.**				
35. Has **set fires** on purpose to cause damage.				
36. Has **broken into** someone else's home, business, or car.				
37. Has **stayed out all night** without permission or **runaway** from home overnight.				
38. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is **fearful, anxious, or worried.**				
40. Is **afraid to try new things** for fear of making mistakes.				
41. Feels **useless or inferior.**				
42. Blames self for problems, feels at fault.				
43. Feels **lonely, unwanted, or unloved;** complains that "no one loves me."				
44. Is **sad or unhappy.**				
45. Feels **different and easily embarrassed.**				
46. Is **overly concerned about health/body.**				
47. Has problems getting along with **you**.				
48. Has problems getting along with **others his/her own age**.				
49. Has problems getting along with **others his/her own siblings**.				
50. Has problems in **group activities** such as games or team play.				
51. Decreased interest or pleasure in all, or almost all, activities of the day.				
52. Has said things like "I wish I were dead" or has tried to hurt self.				
53. Recurrent excessive distress when separation from home or caretakers.				
54. Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).				
55. Has **prolonged temper tantrums** (greater than 20-30 minutes).				
56. Hears voices others to not hear.				
57. Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear).				
58. Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has **recurrent recollections or dreams** of a traumatic event.				
60. Seems to **avoid or have phobias** of specific people, animals, things or situations.				
61. Seems **unaware of others existence**, is **uninterested in interacting with others.**				
62. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness).				
63. Appears **uninterested in activities** children his or her age usually like or participate in.				
64. Has experimented with or abused **drugs or alcohol**.				

(OFFICE USE ONLY) 27—38: ____/ 12 Conduct Disorder: ☐≥ 3 / 12 39—46: ____/ 8 Anxiety/Depression: ☐≥ 3 / 8 47—50: ____/ 4 Social Functioning: ☐≥ 1 / 4 51—64: ____/ 14 Mental Health Concerns

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PARENT QUESTIONNAIRE: School History

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe this child's **strongest** areas in his/her schoolwork:	**2.** Please describe this child's **weakest** areas in his/her **schoolwork**:
a.	a.
b.	b.
c.	c.

HISTORY: School Intervention

Y	**N**	**1.** Has this child been in an **Early Intervention program or Special Day Care/Preschool**?
Y	**N**	**2.** Has this child had **speech, occupational or physical therapy**?
Y	**N**	**3.** Has this child ever **attended summer school**? If Yes, specify subject(s) / grade(s):
Y	**N**	**4.** Has the school ever **discussed this child attending summer school** with you? Specify:
Y	**N**	**5.** Has this child ever **repeated a grade**? If Yes, specify subject(s) / grade(s):
Y	**N**	**6.** Has the school ever **discussed this child repeating a grade** with you? Specify:
Y	**N**	**7.** Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	**8.** Has this child ever received any **special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	**9.** Is this child **currently receiving any special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	**10.** Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify:
Y	**N**	**11.** Does this child need any **special medical assistance**? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **problems reported**? If Yes, please **describe** the teacher or parent concerns in the space provided.

			Academics	**Behavior**
Y	**N**	**1.** Preschool		
Y	**N**	**2.** Kindergarten and First Grade		
Y	**N**	**3.** Second and Third Grade		
Y	**N**	**4.** Fourth and Fifth Grade		
Y	**N**	**5.** Sixth through Eighth Grade		
Y	**N**	**6.** High School		

CURRENT: School Performance Please circle the appropriate number.

	Above Average		**Average**	**Problematic**			**Above Average**		**Average**	**Problematic**	
1. Classroom Assignment Completion	1	2	3	4	5	**8.** Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	**9.** Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	**10.** Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	**11.** Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	**12.** Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	**13.** Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5		1	2	3	4	5

(OFFICE USE ONLY) **School Intervention: Y N** **Academic School Problems: Y N** **Behavior School Problems: Y N** **School Performance: Y N**

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PARENT QUESTIONNAIRE: Child Summary

Child's Name:

HISTORY: Summary

1. Please **summarize your child's OVERALL functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings — home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all settings** to prevent from hurting self or others
7	**Needs 24-hour professional care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

(OFFICE USE ONLY) Impairment: ≥ 4: Y N

MEDICAL PROVIDER USE ONLY

HR: ________ BP: ________ / ________ T: ________ WT: ________ HT: ________ VISION: ________ HEARING: ________

PE:

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