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FAMILY INFORMATION

Child's Name _____ Date of Birth _____ Age _____ Sex _____

Home Address _____ City _____ Zip _____

School _____ Grade _____

Parent's Name _____ Age _____ Sex____ ___ biological ___ adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment_____

Parent's Name _____ Age _____ Sex____ ___ biological ___ adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment_____

Parent's Name _____ Age _____ Sex____ ___ biological ___ adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment_____

Parent's Name _____ Age _____ Sex____ ___ biological ___ adoptive

Phone(H) _____ (W) _____ (Cell) _____

Education _____ Employment_____

Parent(s) with whom child lives _____

Parent Email (used only for direct communication with Dr. Ruch) _____

Others living in household (note age & relationship)

_____ _____

_____ _____

_____ _____

Who referred you for this evaluation? _____

CURRENT CONCERNS ABOUT YOUR CHILD: (check & describe)

___ social problems _____ ___ moodiness _____

___ school behavior _____ ___ academic performance _____

___ eating problems _____ ___ sleep disturbance _____

___ toileting problems _____ ___ other _____

_____

FAMILY CONCERNS: (check if applies)

___ divorce/separation
___ substance abuse
___ adoption issues
___ chronic illness
___ job related problems
___ alcohol abuse
___ child abuse
___ sibling conflicts
___ recent or upcoming move
___ disagreement on discipline of child
___ marital problems: mild—moderate—severe
___ significant losses or traumas

___ other _____

PREGNANCY HISTORY:

___ medications
___ nausea
___ used other drugs
___ toxemia
___ consumed alcohol
___ emotional problems
___ bleeding
___ smoked cigarettes
___ virus/illness

___ other _____

DELIVERY:

Length of labor _____ Medications used _____ Birth weight _____

___ Full term ___Premature (weeks early) _____

Birth complications

___ multiple birth
___ cord around neck
___ caesarean delivery
___ oxygen used
___ breech presentation
___ breathing problems

___ other birth complications _____

Problems & concerns following birth ___ jaundice _____ ___ respiratory problems _____

___ neonatal services _____ ___ eating difficulty _____

___ other post-natal concerns _____

_____

EARLY DEVELOPMENT: (list approximate age)

smiled at parents _____ crawled _____ walked _____

said 5 words _____ spoke in sentences _____ toilet trained _____

PRESCHOOL DEVELOPMENT:

___ sleep problems/nightmares ___ colicky/fussy ___ temper tantrums ___ destructive
___ overactive ___ shy or timid ___ speech problems ___ stubborn
___ uncoordinated ___ eating problems ___ disliked cuddling ___ impulsive

___ other _____

MEDICAL HISTORY: (check & describe)

Physician _____ Current medications _____

___ allergies _____ ___ seizures _____ ___ meningitis _____

___ asthma _____ ___ high fever _____ ___ ear infections/tubes _____

___ hearing loss _____ ___ head injury _____ ___ vision problems _____

hospitalizations/surgeries (date & reason) _____

other injuries (date & describe) _____

Family history of ___ learning problems ___ ADHD ___ alcoholism ___ depression ___anxiety

___ other psychiatric/medical conditions _____

ADDITIONAL COMMENTS OR CONCERNS:

_____

_____

_____

_____

_____

HOME SITUATIONS QUESTIONNAIRE

Child's name _____ Date _____
Name of person completing this form _____

Instructions: Does your child present any problems with compliance to instructions, commands, or rules for you in any of these situations? If so, please circle the word yes and then circle a number beside that situation that describes how severe the problem is for you. If your child is not a problem in a situation, circle No and go on to the next situation on the form.

Situations	*Yes/No* (Circle one)		*If yes, how severe?* Mild (Circle one) Severe								
Playing alone	Yes	No	1	2	3	4	5	6	7	8	9
Playing with other children	Yes	No	1	2	3	4	5	6	7	8	9
Mealtimes	Yes	No	1	2	3	4	5	6	7	8	9
Getting dressed/undressed	Yes	No	1	2	3	4	5	6	7	8	9
Washing and bathing	Yes	No	1	2	3	4	5	6	7	8	9
When you are on the telephone	Yes	No	1	2	3	4	5	6	7	8	9
Watching television	Yes	No	1	2	3	4	5	6	7	8	9
When visitors are in your home	Yes	No	1	2	3	4	5	6	7	8	9
When you are visiting someone's home	Yes	No	1	2	3	4	5	6	7	8	9
In public places (restaurants, stores, church, etc.)	Yes	No	1	2	3	4	5	6	7	8	9
When father is home	Yes	No	1	2	3	4	5	6	7	8	9
When asked to do chores	Yes	No	1	2	3	4	5	6	7	8	9
When asked to do homework	Yes	No	1	2	3	4	5	6	7	8	9
At bedtime	Yes	No	1	2	3	4	5	6	7	8	9
While in the car	Yes	No	1	2	3	4	5	6	7	8	9
When with a babysitter	Yes	No	1	2	3	4	5	6	7	8	9

ADHD RATING SCALE

Child's Name _____ Age ____ Grade ____

Completed by _____

Circle the number in the *one* column which best describes the child.

	Not at all	Just a little	Pretty much	Very much
1. Often fidgets or squirms in seat.	0	1	2	3
2. Has difficulty remaining seated.	0	1	2	3
3. Is easily distracted.	0	1	2	3
4. Has difficulty awaiting turn in groups.	0	1	2	3
5. Often blurts out answers to questions.	0	1	2	3
6. Has difficulty following instructions.	0	1	2	3
7. Has difficulty sustaining attention to tasks.	0	1	2	3
8. Often shifts from one uncompleted activity to another.	0	1	2	3
9. Has difficulty playing quietly.	0	1	2	3
10. Often talks excessively.	0	1	2	3
11. Often interrupts or intrudes on others.	0	1	2	3
12. Often does not seem to listen.	0	1	2	3
13. Often loses things necessary for tasks.	0	1	2	3
14. Often engages in physically dangerous activities without considering consequences.	0	1	2	3