

HMG Pediatrics at Medical Plaza
105 W Stone Drive, Suite 2A
Kingsport, TN 37660
(423) 230-2430

Attention Deficit Hyperactivity Disorder Assessment

Dear Parent/Guardian,

If you have concerns about behavior, attention, or learning problems, we want you to know that we are here to assist you. In order for us to provide a thorough evaluation, it's important that we gather as much information from you as possible for a proper diagnosis to be made. This includes birth history, family history, school history and data (achievement tests, IQ tests, grades, teacher reports, etc.), and other behavioral history.

Many parents and children seek our help because of poor school performance or behavioral problems at school and home. You may have heard the terms "lazy", "poorly motivated", "learning disabled", "short-fused", "hyperactive", "scatterbrained", or "inattentive" used to describe your child. Many times, learning disabilities masquerade as behavioral or performance problems. Therefore, we will need to get measurements of your child's IQ and scholastic achievement level; discrepancies in these areas are indicative of learning disabilities.

Included in this packet are a number of forms for you and for your child's teacher to complete. Be sure to complete the release form which will allow us to exchange information if needed. Upon review of the completed packet, we will contact you to schedule your first appointment. Typically, your child will need to be seen by the physician at least twice to complete an evaluation and provide a proper diagnosis. We want to be sure to take our time and fully understand the challenges your child is facing.

If you have any questions concerning this assessment, please give us a call at (423) 230-2430. Please note that we require a 48 hour cancellation notice if you must cancel your appointment for any reason.

We look forward to working with you and your child.

Thank you,

HMG Pediatrics at Medical Plaza

Health History

Regular Physician: _____

Referring Physician: _____

Date of last physical exam: _____

Are immunizations up to date? Yes No Not sure

Current medications: _____

Any special diet or vitamins? _____

Any foods that are avoided and why? _____

Any allergies? _____

At any time, has your child had the following?

	Never	Past	Present
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or other chronic illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Febrile seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart or blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fever (over 104°)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe cuts requiring stitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury with loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lead Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization more than overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech or language problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye or vision difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine motor/handwriting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross motor difficulties, clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite problems (over/under eating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (falling/staying asleep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soiling problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other health problems, describe: _____

Family Data

Child's Name: _____ Birthday: _____

Adopted? Yes No In School? Yes No

Name of School: _____ Grade: _____

Special Services? Yes No

If yes, please describe: _____

Birth Father's Name: _____ Age: _____ Level of Education: _____

Occupation: _____ History of learning problems? _____

Birth Mother's Name: _____ Age: _____ Level of Education: _____

Occupation: _____ History of learning problems? _____

Marital status: Single Married Separated Never Married

Step Parent's name: _____ Age: _____ Level of Education: _____

Occupation: _____

Name and age of people living with the child. Include parents and other children at home and specify if adopted, foster, or half sibling: _____

If not living with both natural parents, describe any visitation, how often, and any behavioral problems before or after the visits: _____

List any problems with any other members in the family: _____

Have there been any recent changes (good or bad) in the child's life or family?

Family Data (continued)

How did you get referred for this evaluation and what problems are you having?

How long have you recognized this difficulty? _____

Is your child having any behavioral problems? _____

Who handles the discipline at home and how is it handled? _____

	Yes	No
Can your child sit and put a puzzle together?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child sit and read a book alone?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child sit and watch a TV program or video?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child fidget a lot with the TV?	<input type="checkbox"/>	<input type="checkbox"/>

Describe your child's behavior during meals? _____

Describe any behavior problems out in the public: _____

Does your child have any routine chores? If so, describe: _____

If asked to do 3 things at once, how many would your child remember? ___ actually do? ___

How many times has the family moved since your child's birth? _____

How many times has the child changed schools? (please list schools and grades attended).

	Yes	No
Has it been suggested that your child repeat a grade?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child repeated any grades and why?	<input type="checkbox"/>	<input type="checkbox"/>

Family Data (continued)

What have you tried in the past to help your child?

	Yes	No
Do you think your child is depressed or sad for days or longer?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think your child is anxious or nervous a lot?	<input type="checkbox"/>	<input type="checkbox"/>

Have you or your child experienced any unusual or traumatic events in your life recently (i.e. death of a loved one, serious illness/injury to self or loved one, loss of employment, trouble with the law, birth of a child, etc.)?

Family History

Are there any relatives with a history of the following?

	Father	Mother	Sibling	Other
Problems with aggressiveness				
Defiance or oppositional behavior as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with attention, activity, or impulse control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failed to graduate high school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis or schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disease (manic depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression for greater than 1 month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics or Tourettes Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse/Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder (anorexia, bulimia, nervosa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antisocial behavior (assault, theft, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there any problems in the family at this time that are affecting one or more members of the family? (marital, financial, serious illness, etc.)

BIRTH & DEVELOPMENT

PREGNANCY

Was delivery full term, early, or late? _____

	Yes	No
Can your child sit and put a puzzle together?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child sit and read a book alone?	<input type="checkbox"/>	<input type="checkbox"/>
Did mother smoke, take any medications, consume alcohol or drugs during pregnancy?		

Any complications during pregnancy (toxemia, eclampsia, infections, etc.)? _____

LABOR & DELIVERY

Natural, induced or medicated, forceps, C-Section? _____

Birth Weight: _____ Length: _____ Apgars Score: _____

Any health complications after birth? _____

Was oxygen or respirator needed? _____

Was baby alert and responsive? _____

Any jaundice? _____ If yes, what was the treatment? _____

Any congenital problems? _____

If yes, how does it affect your child's life now? Have there been any corrective surgeries in the past? _____

EARLY CHILDHOOD DEVELOPMENT (The first year of life)

	Yes	No		Yes	No
Severe colic	<input type="checkbox"/>	<input type="checkbox"/>	Feeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	Eating problems	<input type="checkbox"/>	<input type="checkbox"/>
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Head banging	<input type="checkbox"/>	<input type="checkbox"/>
Rocking behavior	<input type="checkbox"/>	<input type="checkbox"/>	Clumsy	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive	<input type="checkbox"/>	<input type="checkbox"/>	More active than expected?	<input type="checkbox"/>	<input type="checkbox"/>

How old was your child when sitting? _____ Walking alone? _____

Talking? _____ Toilet trained? _____

Were there any serious illnesses, hospitalizations, or surgeries? If so, please list approximate dates and ages? _____

Has your child ever had seizures, blackout spells, or serious head trauma? _____

HOME SITUATIONS QUESTIONNAIRE

Child's Name: _____ Date: _____

Name of person completing this form: _____

DOES THIS CHILD PRESENT ANY BEHAVIOR PROBLEMS IN ANY OF THESE SITUATIONS?
IF SO, PLEASE INDICATE HOW SEVERE THEY ARE.

	YES	NO	SEVERITY SCALE MILD (1) TO SEVERE (9)								
While playing at home	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While with other adults	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While with other children	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
Mealtimes	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
Washing/Bathing	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While you are on the phone	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While watching TV	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
When visitors are in your home	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
When you are visiting someone	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
In stores	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
In churches	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
In restaurants	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
Other public places	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
Doing routine work at home	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
When asked to do chores	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
At bedtime	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While in the car	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
While with a babysitter	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
When father is home	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9
When doing homework	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9

BEHAVIOR HISTORY

For at least the past six months, has your child demonstrated any of these behaviors considerably more frequently than most other children the same age?

Please check all that apply.

- Has difficulty remaining seated when required to
- Often fidgets with hands or feet or squirms in the seat
- Sense of internal restlessness
- Has difficulty playing quietly
- Often talks excessively
- Often shifts from one uncomplicated activity to another
- Has difficulty following instructions
- Is easily distracted
- Often interrupts or intrudes on others
- Often blurts out answers to questions before completed
- Has difficulty waiting in lines or in group situations
- Often engages in physically dangerous activities/thrill-seeking
- Is often extremely messy or sloppy
- Often loses things needed for finishing tasks at home or school
- Often does not seem to listen to what is being said
- Delays in getting fully dressed
- Lingers or delays at mealtime
- Slow in getting ready for bed
- Gets angry when not getting his/her own way
- Cries easily
- Is careless with toys, hobbies, and other objects
- Engages in excessive imaginary play
- Hears voices or noises that are not there
- Sees things that other people do not see
- Often deliberately does things that annoy people
- Often blames others for mistakes
- Often lies without thinking of consequences or to cover up mistakes
- Diminished pleasure in activities or friends
- Suicidal ideation or attempt
- Overreacts to touch
- Has compulsive rituals
- Motor tics
- Vocal tics
- Has panic attacks
- Excessive or inappropriate reaction to change in routine

REQUIRED 48 HOUR NOTICE

Please note that we require a 48 hour notice for paperwork and perscription refill requests. These requests are time consuming to complete and last minute phone calls and walk-in requests cannot be honored unless deemed medically necessary by our staff.

In order to provide the necessary attention to patients with scheduled appointments, we ask that you please plan ahead and allow the necessary time for us to process your requests.

We appreciate your cooperation and consideration of other patients and apologize for any inconvenience this may cause.

HMG Pediatrics at Medical Plaza

I have read the above statement and understand as noted by my signature below:

Signature

Date

BEHAVIORAL HEALTH APPOINTMENT CANCELLATION & NO SHOW POLICY

HMG Pediatrics at Medical Plaza requires a 48 hour cancellation notice for all behavioral health appointments. Because these appointments are typically longer time slots to address very complex and often chronic concerns, providing us at least 48 hours notice of any cancellation allows our team members the time to reach other patients who might be able to utilize your appointment time.

Please note that Holston Medical Group will bill the responsible party a fee of \$87.00 for missed behavioral health appointments without the necessary 48 hour notice prior to the scheduled appointment time.

I have read the above statement and understand the policy as stated. I have also been given the opportunity to ask any questions and voice any concerns. My consent to abide by this policy is noted by my signature below.

Failure to consent to the above policy will require that you find another provider to meet your child's behavioral needs.

Responsible Party

Date

Witness

Date

EDUCATIONAL HISTORY

NAME OF SCHOOL: _____

Is your child currently having trouble in school? YES / NO

Learning Problems? YES / NO

Behavior Problems? YES / NO

Social Problems? YES / NO

What were your child's most recent report card grades? _____

Last year's report card grades? _____

Is your child now or has he/she ever been in special ed classes or resource room? YES / NO

Has your child repeated any grades or been recommended to repeat a grade? YES / NO

If so, what reason did the school provide? _____

Describe any problems your child had in daycare or nursery school: _____

Did your child enjoy the last full year of school? YES / NO

What was your child's strongest area in school? _____

What was your child's weakest area in school? _____

What is your child's most effective way of studying/learning style? _____

How does your child's current teacher describe your child? _____

Have other year's teachers had similar or different opinions? _____

Do you agree with this evaluation of your child? YES / NO

Has your child received a psychological or educational evaluation through the school? YES / NO

When? _____ (Please bring a copy with you to your appointment with us)

Summarize results: _____

Has your child had any mental health treatment? YES / NO

If yes, when and how helpful was it? _____

How many caffeinated drinks does your child consume in a day? (tea, coffee, soda) _____

Is your child now or in the past been cruel to or hurt animals? YES / NO

Has your child ever set fires? YES / NO

Has your child ever tried to hurt any family member? YES / NO Anyone outside the family? YES / NO

Has your child ever tried to hurt themselves or commit suicide? YES / NO

Is your child currently thinking of suicide? YES / NO

Has your child ever gained or lost a lot of weight in a short period of time? YES / NO

Do you have any concerns about your child's diet/weight? _____

Does your child have trouble sleeping? YES / NO What do you do? _____

Does your child play as much or the same as other children the same age? YES / NO

Does your child smile and laugh as much as he/she used to? YES / NO

Does your child seem depressed? YES / NO

***Please use the back of this page to describe your child's personality, favorite/least favorite things, hopes and fears, hobbies, etc. in order for us to get to know him/her better.*

HMG Pediatrics Release Form

Behavioral Health Treatment

My child's teacher, _____, as well as the school principal and counselor at _____ school has my permission to release academic, behavioral, and social and emotional information on my child to HMG Pediatrics. In addition, I also allow permission for the teacher, principal, and counselor to discuss their difficulties and/or progress with my child with HMG Pediatrics in order to address my child's behavioral health needs. This permission to contact the school will continue unless a written instruction to the contrary is received by the physician's office. I understand that my child cannot be evaluated without this consent.

Parent/Responsible Party Signature

Date

Parent/Responsible Party Printed Name

Address: _____

Telephone #: _____

School Name: _____

School Address: _____

School Year: _____

School Telephone: _____