A.D.D. Clinic, Inc.

7381 W. Charleston, #130 Las Vegas NV 89117
Phone: 702.736.1919 Fax: 702.736.1016
e-mail: drc@addclinic.net
Web: www.addclinic.net

Corydon G. Clark, M.D.
Medical Director

Linda West
Office Manager

New Patient History
For Children & Adolescents

Evaluation Questionnaires

Directions:

Please complete this entire packet very carefully before arriving for your first appointment at the A.D.D. Clinic. As you see, it will take at least 2-3 hours for parents and up to 1 hour for children to answer the hundreds of questions you are asked to respond to in these Initial evaluation materials. The time you devote to the task will be well worthwhile: The A.D.D. Clinic physician will be substantially aided in developing an accurate diagnosis and effective treatment plan quickly with these completed materials in hand from the start. **Please answer ALL QUESTIONS; do not skip any. If a question does not apply please mark it with an N/A.**

Please mail this packet back to the Clinic or drop it off 4-5 days ahead of time so the physician who will see you and your child will have a chance to review all these materials well in advance. Also, please arrange to arrive at the Clinic at least 30 minutes early for your appointment.

Please do not "race through" the questions! It is very important all details be thoroughly completed, e.g., especially precise names and doses of any medications previously employed, and the symptom checklists, among many other matters.

We always prefer both parents attend the Initial Evaluation Session whenever possible. It is usually highly important if other family members such as, siblings, aunts, uncles, and (especially) grandparents can attend as well – especially those who play an important care-taking role for the child or adolescent.

For the convenience of our patients and families, physicians at the A.D.D. Clinic are very careful to "stick to their schedule."

You should find in this "packet" Directions to the A.D.D. Clinic, including an area map, and a note confirming your appointment date and time. The following forms and questionnaires should be enclosed.

1. Scheduling & Services Information

FOR PARENTS TO COMPLETE:

2. Patient Registration Form
3. Residence & Employment Information
4. Why Are You Here
5. Development & Health Form
6. Child's Prior Treatment History
7. Family History
8. Developmental Mastery Questions
9. School Information Form
10. Modified Attwood Questionnaire
11. Reasoning, Empathy, & Attention Questions
12. Interpersonal Interaction Questionnaire
13. Anxiety Questionnaire
14. Temperament Rating Scales
15. ADI Diagnostic Questions
16. Mood, Obsession, Compulsion, & Tic Symptoms

FOR TEACHERS TO COMPLETE: (If the child is in elementary school.)

17. Vanderbilt Teacher Behavior Evaluation Scale **(*insert)**

FOR CHILD TO COMPLETE:

18. C.A.M.S.S.
19. Kid's Questionnaire
20. Kutcher Adolescent Depression Scale

SCHEDULING & SERVICES

FIRST FOLLOW UP APPOINTMENT:

This is typically scheduled 1-3 weeks after the initial appointment, and is normally a 30-minute appointment in uncomplicated cases. There are many exceptions to this "general rule", especially arising when additional testing appears to be required, another family member clearly requires evaluation or treatment, or when the child/adolescent needs additional personal interview time.

We hope parents will try to read all materials in Child Packet # 1 before the first follow up appointment, and adolescents 12 and older read all papers and materials *appropriate for their level* by then as well.

For children in Elementary School, please make sure their teacher has directly provided to the parent or FAXED to the Clinic a Progress Form describing progress during the past 2-3 weeks. (If school is in session).

ALL CONCERNED RELATIVES, ESPECIALLY GRANDPARENTS, are welcome at follow-up meetings. This is a critical session for review of questions and concerns we need to cover early in treatment, so please bring a list if you need reminders about what to discuss.

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This is usually when the treating physician and parents (including children when appropriate) should discuss possibly employing one or more of a variety of services which the child, adolescent, or family member may need for further evaluation or treatment:

FEES for follow-up services:

15-minute physician services $120.00
30-minute physician services $225.00
45-minute physician services $325.00
60-minute physician services $400.00

Psychological Testing: Fees will depend upon the complexity of the tests to be given. The exact cost will be quoted to parents and agreed upon before psychological testing is scheduled.

EKG $100.00

Prescriptions written between appointments, called in to a pharmacy, FAXED to a pharmacy or picked up – per patient charge is $10.00.

*** All fees are subject to change without prior notice.

AVAILABLE SERVICES:

Expert Cognitive/Behavioral Therapy for OCD and Related Disorders
Individual Psychotherapy/Counseling for all major conditions
Family Therapy "
Parenting Counseling & Training
Individual & Couples Counseling for Substance Abuse Disorders
Couples Therapy for Adults
Comprehensive Psychiatric Evaluation & Treatment for Parents, Siblings and other family members
Developmental/Growth Examinations/Evaluations
Electrocardiogram [EKG]
Monitoring of Height, Weight, Pulse, and Blood Pressure

In addition to treating patients of all ages for all facets and complications of ADHD, we have highly specialized psychiatric and psychological programs in place to treat patients who have:

Asperger's Disorder
Obsessive-Compulsive Disorder
Tourette's Syndrome
Other mental & emotional conditions
Major Depression
Bipolar Disorder
Anxiety Disorders

PATIENT REGISTRATION FORM

DATE:_____

PATIENT NAME:_____
SSN#:_____AGE:_____DOB:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME#:_____WORK#:_____CELL#:_____

RESPONSIBLE PARTY /PARENT / GUARDIAN INFORMATION:

NAME: _____SS#_____

DATE OF BIRTH _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME #: _____WORK#_____CELL#: _____

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

EMPLOYER PHONE: _____EXT: _____

RELATIONSHIP TO PATIENT: (please circle all applicable)

SELF SPOUSE MOTHER FATHER GRANDPARENT AUNT UNCLE STEP-PARENT

LEGAL GUARDIAN IF PATIENT IS A CHILD

INSURANCE INFORMATION

INSURED NAME:_____
DOB OF INSURED:_____
INS. COMPANY:_____
GROUP#:_____
MEMBER#:_____
POLICY#:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
INSURANCE PHONE#:_____
RELATIONSHIP TO INSURED:_____

PLEASE READ BEFORE SIGNING:

This form is a contract between patient and physician and must be signed prior to receiving any services.

**(NOTE: The "I" statement in this agreement also refers to any dependents being treated.)

I understand that I may be charged full fee for appointments that are not cancelled 24 hours prior to the time of the appointment, unless the appointment is changed due to a bona fide emergency.

I understand that all fees are to be paid at the time of service.

I authorize the A.D.D. Clinic, Inc. to perform services required for evaluation of the presenting condition(s). The treating physician will discuss proposed treatment with patients and families before therapy is initiated.

I understand that I am responsible for all court costs, interest and legal fees if my account goes into collections.

I understand that I will be charged a fee of $25.00 for all checks returned by the bank.

I stipulate that I am the custodial parent or legal guardian if the patient is a minor, and I am legally authorized to obtain medical care.

I understand that the A.D.D. Clinic, Inc. is not a provider for ANY insurance company. Payment is expected at the time of each visit. If you have insurance and want it billed, we will submit it for you and any monies paid to us will either get credited on your account for further visits, or reimbursed to you. Any authorizations necessary and required by your insurance company, is solely your responsibility, but we will try to assist in every way we can.

I understand that if there is any change in my: address, telephone number, and responsible party, it is my sole responsibility to inform the A.D.D. Clinic, Inc.

I understand that I must allow 24 hours for medication refills and picking up prescriptions when called into the office. When a pharmacy calls the office it will take up to 6 hours or more before they can be called in. A doctor must authorize all refills/prescriptions. We cannot process prescription refill requests called in after 4 PM Friday until 10 AM Monday morning. If you request to have prescriptions mailed to you, there will be a $10.00 fee for this service each time.

I understand that I will be charged $0.60 cents per page for copying of medical records.

I understand that I will be charged for special reports and letters. This fee is based on time and difficulty of report(s). The physician, therefore, will determine this fee.

I certify that all the information I have provided is true and correct. (INITIAL)_____

I have read and understand all the paragraphs above. (INITIAL)_____

SIGNED: _____DATE: _____
Responsible party (Patient Signature) If minor: Signature of Parent / Guardian

RESIDENCE & EMPLOYMENT INFORMATION

PATIENT NAME: _____
BIRTH DATE: _____
ADDRESS: _____
CITY: _____STATE: ____ZIP CODE: _____
HOME#_____

Best # to reach parents from 9-5 to confirm appointment:_____

PARENTS NAMES:_____
Employer Name (Mom)_____
Work Tel# _____Cell #_____
Occupation: (describe what you do at work)_____
_____
E-Mail Address:_____

Employers Name (Dad) _____
Work Tel#_____Cell #_____
Occupation: (describe what you do at work)_____
_____
E-Mail Address: _____

NAMES AND AGES OF OTHER CHILDREN:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

PATIENT RESIDES WITH:

____Natural mom and dad
____Dad only
____Mom only
____Mom & Stepfather
____Dad & Stepmother
____Grandmother___Grandfather___Both___
____Adoptive Mom___Dad___Parents___
____Other(describe)

Custody Issues: Please be very specific! _____
_____
_____

VISITATION SCHEDULE (If applicable):

WHY ARE YOU HERE?

Who referred you to the A.D.D. Clinic?_____
Why were you referred to us?_____
_____
_____

Does your child currently see a counselor or therapist? Yes _____No_____

If so, who, why, and for how long?_____

What do you hope we will be able to do to help your child?

Which problems are most troublesome right now?

What have you told your child about being here today?

If there is ANY question or ambiguity about legal and physical custody of this child, do you stipulate you have legal authority to arrange for medical and psychiatric care? ___Yes___No.

In shared custody situations, we strongly encourage both parents to attend initial diagnostic sessions and conjointly participate in treatment planning, and then both attend follow-up meetings here as often as possible.

DEVELOPMENT AND HEALTH

This patient was your ____ child (1st, 2nd, etc.) Was this pregnancy planned? Yes___NO___
Was this pregnancy welcomed by both parents? Yes___No___ If No, please explain:

Were there any complications during pregnancy? Yes___No___ If Yes, please explain:

Use of nicotine, alcohol, or other substances during pregnancy? Yes___No___

Birth Weight___Lb___Oz. APGAR score, if known___. Full Term? Yes___No___If No, how many weeks Pre-mature or Post-mature?_____

Any major complications of delivery?

Age in months when child began to crawl or creep___ walk___ run___ use single words___ use short sentences___ understand directions___ toilet trained___

Were there any unusual or severe early childhood illnesses, e.g., colic, frequent ear infections, food or lactose intolerance, febrile seizures, etc.?_____
_____

Has the child received all immunizations on schedule? Yes___No___

Child's Pediatrician or Family Physician: (Name)_____
___My child does not have a personal physician at this time.

Date of last physical examination:_____Date of most recent lab work:_____

Does your child have any medical condition CURRENTLY being treated with ANY medication? Yes___No___

If so, what condition, and what medication?***

Condition:_____Medication:_____Exact Dose:_____
Condition:_____Medication:_____Exact Dose:_____

*** A.D.D. CLINIC PHYSICIANS MUST HAVE THIS INFORMATION AVAILABLE AT THE VERY FIRST PORTION OF THE FIRST INTERVIEW! We cannot properly evaluate nor hope to effectively treat a child when we are told he/she is taking a "little blue pill" for "stomach upset" and a "squeezy" inhaler for asthma! You would not believe how often this is what we are told in the first interview!

Has your child EVER had an operation of any kind, diagnosis or treatment for ANY major illness, injury, accident, or other condition? If so, what, when, where, and please indicate the outcome:

Do you suspect, or have concerns about, ANY possible physical condition or problems which might be affecting your child NOW? If so, please state:

Does your child have a tendency to dramatize (or "overreact" to) trivial bodily sensations? (e.g., a trivial queasy stomach becomes so awful your child goes to the school nurse) Yes___No___

Does your child now have, or has ever had, any of the following conditions?

ASTHMA Yes___No___ If Yes, when?_____ What treatment was/is provided?
_____

ALLERGIES to any medications, foods, or supplements Yes___No___ If Yes, which medications, foods, etc.?_____

EPIEPSY/SEIZURES Yes___No___ If Yes, when?_____ What treatment was/is provided?_____

BRAIN INFECTIONS, e.g., ENCEPHALITIS or MENEGITIS Yes___No___If, yes when?

SERIOUS BRAIN INJURY from TRAUMA Yes___No___If Yes, When?_____

Describe severity:

THYROID HORMONE ABNORMALITY Yes___No___If Yes, what type? What treatment is being provided?_____

RECURRENT, VERY FREQUENT INNER EAR INFECTIONS Yes___No___

RECURRENT, VERY FREQUENT "STREP THROAT INFECTIONS" Yes___No___

Does your child seem to have a PATTERN where tics, obsessions and/or compulsions, or hyperactive behavior appears to become much worse 7-14 days after Strep Throat infections? Yes___No___ If Yes, when did you first notice this, and how long has this pattern gone on?
_____

SEVERE HEADACHES Yes___No___ If Yes, do you suspect these may be Migraine Headaches? Yes___No___ If Yes, why?_____
Any prior diagnosis or treatment?

OTHER HEALTH PROBLEMS: Check any that *currently* apply.

___Bedwetting
___Night Terrors
___Poor fine motor coordination
___Poor large motor coordination
___Appears small for age
___Nail biting
___Twirls hair constantly
___Pains in knees and other joints
___Unusually dry skin
___Unexplained fainting
___High or Low Blood Pressure
___Recurrent constipation
___Complains of feeling cold in warm rooms/weather
___Frequent nightmares
___Sleepwalking
___Slow speech/articulation development
___Tremors in hands
___Starting puberty too soon
___Picks at skin excessively
___Very susceptible to infections
___Frequent stomach aches
___Excessive sweating
___Ulcer
___Frequent diarrhea
___Delayed onset of puberty
___Complains of feeling hot in cool rooms/weather

Please mention here any other concerns you have about your child's health:

CHILD'S PRIOR TREATMENT HISTORY

Many children we evaluate and treat in a specialized Clinic of this kind have been "Through the Mill," as it were, of a variety of prior counseling efforts and failed medication treatment attempts. Therefore, it is vital we learn as much as possible about what worked, what didn't and what went wrong.

Has there been prior counseling or psychological treatment? Yes___No___ If yes, please describe:

By whom:
When:
Where:
Using what method(s):
Achieving what results:
What were the positive and negative facets of prior psychological treatment?

Has there been any prior Occupational Therapy, Movement, Eye, Lens, Sensory Integration, Neurofeedback, or other treatment? If so, please discuss outcome:

Has there been any prior Homeopathic treatment? Yes___No___ If Yes, please describe:

Has there been prior (standard) medication treatment? Yes___No___ If Yes, please describe in detail:

Name(s) of medications employed:

Precise doses used:

Dates these medications were given:

Who prescribed these medications?

What were the positive results, if any?

What were the side effects, if any?

Why did you discontinue treatment with each of these medications?

Have you done additional research about newer medications?

FAMILY HISTORY

Have any biologically – related family members been **diagnosed** with, and treated for, any of the following conditions – or – do you strongly **suspect** any family member has one of these conditions in undiagnosed and untreated form?

CODE: D- Diagnosed S-Suspected

	Mother	Father	Grandmother	Grandfatherr	Sister	Brother	Aunt	Uncle	Cousin	Other
Attention Deficit Disorder, A.D.D. or Hyperactivity										
Bipolar Disorder (Manic-Depressive Disorder)										
Major Depression										
Obsessive-Compulsive Disorder										
Tourette's Syndrome										
Asperger's Disorder or any form of Autism										
Panic Disorder										
Other Anxiety Disorders, e.g. Phobias										
Hyperthyroidism										
Hypothyroidism										
Stroke										
Sudden death from cardiovascular "accidents"										
Migraine Headaches										
Cholesterol Disorders										
Anemia										
High or Low Blood Pressure										
Unexplained loss of consciousness										
Ulcers										
Serious Kidney Disorders										
Familial Obesity										
Diabetes										
Other important health conditions (specify)										
Other serious mental disorders (specify)										
Other rare genetic and /or developmental syndromes (specify)										

DEVELOPMENTAL MASTERY QUESTIONS

These are more fun! Please address how your child responded to the following developmental "crises."

1) Separating from Mom/Dad and going to Pre-School / Kindergarten:

2) First trip to the Dentist:

3) First trip to the Barber:

4) Visits to the Doctor before age 6:

5) Discovery of the identity of the Tooth Fairy & (if applicable) Easter Bunny & Santa Claus:

6) Most recent visits to the Doctor:

7) Has your child ever had an imaginary friend? What was the friend like?

8) Has your child ever been "in love" with another child? How old was your child then, and how did that turn out?

9) Has there ever been a *seriously traumatic event* in your child's life, such as physical or sexual abuse, death of a parent, sibling, or important caretaker? If so, please describe:

10) Does your child seem to cling to "magical" ideas about things he or she is anxious about or especially interested in? If so, please describe:

11) Does your child appear to be fearful or anxious about growing up? If so, please describe how that is expressed.

SCHOOL INFORMATION FORM

Please respond to these questions carefully, since for most children and families we treat these are among the most difficult dilemmas we have to try to help solve.

My child attends _____School
He/she is in _____ Grade (or will be entering _____ Grade, if it is summer when you complete this form)
Name of teacher(s), if in Elementary School: _____
School phone number _____ School FAX number _____
Type of class: Regular ___ Special Ed ___ Resource ___ GATE ___ Self-Contained ___ Other___

Does your child have an IEP or 504 accommodation plan? Yes___No____
Has your child ever been required to repeat a grade? Yes___No___
Has this been suggested? Yes___No___
Has your child ever been promoted a grade ahead? Yes___No___
Has this been suggested? Yes___No___
Are you satisfied with your child's school and/or class placement? Yes___No___If No, please discuss why not:

Are you satisfied with your child's teacher or teachers? Yes___No___If No, please discuss why not:

Is your child: ___Working above grade level in most subjects
___At grade level in most subjects
___Below grade level in some or most subjects If so, which specific subjects?

Has there been any educational testing performed by school psychologists? Yes___No___
If so, please arrange to bring us copies you have on hand, OR have the School send us a copy as soon as possible.

Has there been any intelligence, personality, or learning-related testing performed by OTHER psychologists? Yes___No___ If so, please arrange to bring a copy of that testing to the initial interview if at all possible.

Is your child HAPPY at this school? Yes___No___ If No, why not?

Please describe concerns you may have about:

The peer and social environment at your child's school.

Your Child's teacher(s).

Your child's homework load and ability to complete homework in a reasonable amount of time.

Your child's ability to understand concepts at grade level.

Do you feel your child needs special help in any particular academic area?

Are these needs being met at the school?

Are you considering enrolling your child in another school? Yes___No___If Yes, why?

MODIFIED ATTWOOD QUESTIONNAIRE

Please rate your child on a scale of 0 – 5 in each of these areas. 0 = Infrequent or Very Uncharacteristic of your child, to 5 = Common or Characteristic of your child, numbers 1 – 4 being intermediate. Write in the number you feel fits your child best in the blank on the left.

___ 1. Seems to lack understanding of how to play with other children.

___ 2. Typically avoids play with same-age children.

___ 3. Attempts to be the "Boss" of younger children when playing with them.

___ 4. Seems unaware of social conventions; makes offensive personal remarks.

___ 5. Seems to lack understanding of other people's feelings.

___ 6. Becomes very upset when routine is changed or exact demands not met.

___ 7. Disinterested in competitive sports, games, and activities.

___ 8. Rarely expresses interest in, or concern about, what other children think or do.

___ 9. Interprets comments literally, missing the "point."

___ 10. Does not get the "point" of others' jokes, and tells jokes which others cannot interpret.

___ 11. Speaks in an unusual tone of voice, akin to a monotone, without usual inflection and emotional expression.

___ 12. Does not appear to listen closely or be interested in others' ideas or opinions.

___ 13. Eye contact often difficult to obtain, and very hard to maintain.

___ 14. Speech seems too precise, too formal, as if lecturing, especially with other children.

___ 15. Disinterested in "stories" or imaginary themes; seems to read to acquire information.

___ 16. Unusual long-term memory for facts and events.

___ 17. Rarely interested or able to engage in any imaginary play games with other children.

___ 18. Fascinated by, or fixated upon, a particular topic, often one which appears VERY UNUSUAL and VERY ODD for a child of that age.

___ 19. Very poor gross motor coordination, e.g., throwing a ball, catching or kicking a ball, etc.

___ 20. Odd or unusual gait while walking or running.

___ 21. Seems unable to learn, or refuses to try to learn, skills such as hopping, skipping, jumping rope, jumping jacks, push-ups, riding a bike, and similar child games.

___ 22. Afraid to try, VERY SCARED OF, "high-stimulation" Theme Park activities such as Roller – Coasters, spinning and whirling "Tops," Ferris Wheels, etc.

___ 23. Extremely oversensitive to, and distressed by, ordinary sounds & noises, being touched, labels and certain fabrics in clothing, certain aromas (smells), noisy places, crowds, colors, etc.

___ 24. Tendency to remember and maintain these fears or distress for months or years as if they were still "fresh" in mind, with a corresponding *intense resistance* to "letting go" and trying again.

___25. Is <u>exceptionally</u> rigid and uncompromising about what he/she will or will not eat.

___26 Asks incredibly bizarre questions as if "out of the blue", often far beyond anything parents imagine a child that age would wonder about.

___27. Demands very precise answers even when his/her questions are obscure.

___28. Becomes very upset or angry when children he/she is playing with do not follow unique rules of own invention.

___29. In play with other children, seems preoccupied with personal mastery or control of the game rather than playing for enjoyment.

___30. Selectively refuses to attempt to learn or study certain specific academic subjects, read certain books, or do particular math projects usually for completely obscure reasons.

PARENTS: Please add any other comments or concerns you would wish to communicate to help our staff understand the situation. It is always useful to make a large **X** or **XXX** in a felt pen next to the characteristics which generate most difficulty in your child's development.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REASONING, EMPATHY, & ATTENTION QUESTIONS

Please rate your child on a scale of 0 – 5 on each of these questions, with 0 = Infrequent or Not Characteristic of child, to 5 = As Almost Always or Very typical of your child, using 1 – 4 for intermediate ratings.

Please indicate with a X, XX, or XXX which of these characteristics is of special concern to you, and describe them further in your own words:

____ 1) Blurts out responses to questions impulsively.
____ 2) Jumps to conclusions without thinking carefully.
____ 3) Often cannot explain why he/she has reached a decision or conclusion.
___ 4) Considered naïve by same-age peers.
___ 5) Easily frustrated when required to pay close attention to long, detailed projects.
___ 6) Quick to stick up for or help other children when they are in danger or hurt.
___ 7) Shares own toys, games, and personal objects generously with siblings and other children.
___ 8) Fierce, nasty temper outbursts.
___ 9) Pouts, whines, & cries easily and often when frustrated.
___ 10) Feelings easily hurt when teased or taunted by other children.
___ 11) Lashes out with anger and aggression when feelings hurt.
___ 12) Withdraws, cries, and seeks out parents for solace when feelings hurt.
___ 13) Picked on and or target of "bullying" by other children.
___ 14) Selectively plays with younger peers.
___ 15) Seems unusually attracted to playing with children of the opposite sex.
___ 16) Expresses fears of injury and/or illness.
___ 17) Asks many questions about morbid themes, e.g. death, dying, illnesses, etc.
___ 18) Very curious about VERY ODD things.
___ 19) EXTREMELY PRIVATE and guarded about what he/she draws, reads or writes.
___ 20) Reluctant, or refuses to join same-age peers in rough-and-tumble games and horseplay.
___ 21) Dresses in clothing of opposite sex.
___ 22) Insists on using age-inappropriate make-up.
___ 23) Extremely curious about (and/or)____ discovered engaging in sexual behaviors at a very young age.
___ 24) Sexual activity has been at times, a matter of parental concern.
___ 25) Normally happy, "upbeat," playful, good mood.
___ 26) Seeks exceptional attention and reassurance at bedtime.
___ 27) Insists parents follow certain precise rituals or he/she becomes very upset.

CURRENT PROBLEMS

Please continue to use the 0-5 and the X rating scale as on prior page.

___ 28) Failure to give close attention to details or makes careless mistakes in schoolwork or other activities.
___ 29) Difficulty sustaining attention in routine tasks or play activities.
___ 30) Difficulty with listening when spoken to directly.
___ 31) Difficulty following through on instructions and failure to finish schoolwork or chores. {This is NOT due to failure to understand the instructions}.
___ 32) Difficulty *organizing* tasks and activities.
___ 33) Avoids, dislikes, reluctant to engage in tasks requiring sustained mental effort.
___ 34) Loses things necessary for tasks and activities, like pencils, assignments, books, etc.
___ 35) Easily distracted by all kinds of sights, sounds, classmates activities, own thoughts and impulses, etc.
___ 36) Forgetful in almost all daily activities, at home and at school.
___ 37) Called an "Absent-Minded Professor" or "Space Cadet" by friends and family members.
___ 38) Appears to spend an exceptional amount of time daydreaming.
___ 39) Fidgets, squirms and wiggles hands and feet, and seems extremely restless.
___ 40) Difficulty remaining seated at school, at the dinner table, or elsewhere despite being required to do so.
___ 41) Overactive and far more restless than similar age children.
___ 42) Rarely quiet.
__ 43) Is often on the go or acts as if "driven by a motor".
___ 44) Talks excessively, even when being quiet is socially required.
___ 45) "Pops out" with answers or conclusions before listening to the whole question or problem.
___ 46) Has difficulty waiting for his/her turn in games and activities.
___ 47) Interrupts and intrudes on others' activities or conversations.
___ 48) Disruptive in group activities.
___ 49) Picks on, bullies other children.
___ 50) Becomes VERY WOUND UP in stimulating situations.
___ 51) Difficulty settling down and getting to sleep on a routine schedule.

Please place a *****, ******, or ******* on the left margin next to characteristics which best describe the most important concerns you have about your child.

How old was your child when you first became concerned he/she was developing significant problems? _____

Do you have other children, (or any other family members), who have some of these characteristics? Yes___No___ If so, please discuss:

INTERPERSONAL INTERACTION QUESTIONNAIRE

On a scale of 0 (Uncharacteristic of your child) – 5 (Very characteristic of your child) , using 1-4 for intermediate ratings to these traits:

Parents – Mark XX or XXX next to item of greatest concern

a) ___Resists, avoids, pulls away from, or objects to being TOUCHED by many or most people.

b) ___Fierce, angry, NASTY temper "flare-ups" when he/she feels misunderstood or rejected.

c) ___Nearly phobic avoidance of any/all age-appropriate sexual themes, jokes, or movies, TV shows, etc – as if "Monkey can't stand hearing or seeing this!

d) ___Remarkably quick and exceptionally severe morally-based (and then "fixed") or "judgmental" assessments of peers, teachers, other adults, etc.

e) ___Is extremely abrupt, intrusive, inappropriately direct in questions even of strangers. Seems totally lacking in age-appropriate "diplomacy", e.g., at age 14 upon meeting an uncle at a family gathering: "How do you do, Uncle Winston? You smell old!

f) ___Often seems restless, uncomfortable, and preoccupied, but unable to explain what might be bothering him/her.

g) ___Cannot, despite all manner of adult assistance, seem to comprehend HOW to play any game NON-COMPETITIVELY. Cannot grasp HOW he/she might give a younger children a "chance to win" any game in which he/she has superior skills. ALWAYS plays to win no matter how this impacts on the other player(s).

h) ___Fixates on one, and only one, clear and definite reward for success in any give behavioral or academic task. FEROCIOUSLY resists any compromise or change!

i) ___Will almost never "negotiate." Seems unable to comprehend the concept of negotiation.

j) ___Sees his/her world in terms one may describe as "Black or White", "Good or Evil."

k) ___Is consistently unable to comprehend, understand, or respond normally to any form of IDIOMATIC expressions. Does not "get the point" of common expressions, such as: "Tommy had butterflies before he took that test!", "That" explanation is as clear as mud.", "Wow! That is a really HOT car!"

l) ___Not only cannot play sports, but detests sports, feeling there is no *logical* basis for playing any sporting game.

m)___Unable to consistently follow parent/teacher guidelines and keep his/her hands off peers during playground and/or neighborhood activities. Despite frequent correction, hands stray onto forbidden territory repeatedly.

n) ___Fixation on sexually age-inappropriate themes; resists parent correction.

o) ___Development of a *very* intense fixation and fantasy of a loving attachment to a peer of the opposite sex approaches bizarre levels, with fiercely angry reactions when these fixations are rejected.

p) ___Personal effects, e.g. own room, contains objects and items arranged in a completely incomprehensible order. The child insists on this order and arrangement, and becomes extremely upset if anything is moved or changed at all.

q) ___EXTREMELY BRIGHT – in all advanced placement technical classes. Knows math, science, engineering, physics, chemistry or other subjects at a remarkably sophisticated level.

r) ___Has very, very few friends, and seems to have to have no idea how to go about making friends.

s) ___Seems very dependent upon other kids approaching him/her to make friends; CANNOT succeed in taking the initiative by self.

t) ___Remarkably critical of anyone making an inaccurate/imprecise statement, e.g., Mom: "He saw his pediatrician last month." Child: "That was three months ago!"

u)___One or more parent, grandparent, aunt or uncle has similar child/adolescent history or current symptoms.

ANXIETY QUESTIONNAIRE

Please rate your child on a scale of 0– (Not Characteristic) to 5- (Very Characteristic), using 1-4 for intermediate ratings to these traits:

____ Cries very easily when frustrated or disappointed.
____ Seems extremely sensitive to criticism.
____ Seems extremely shy.
____ Clings to Mom or Dad when in presence of strangers.
____ Usually cannot get to sleep in own bed____or stay in own bed all night.
____ COMPLETELY "freaks out" if seen naked by ___siblings or____ other family members (Who?)
____ Fearful of certain household appliances, e.g. ___flushing toilets___vacuum cleaners ___washing machines or dryers___Other:
____ MONSTERS are still a problem, e.g. under the bed, in the closet, etc.
____ Noises outside at night frighten your child.
____ You have difficulty going out in the evening due to your child's fear of separation from you.
____ Your child has rarely been able to trust and go to bed while supervised by ANY baby sitter outside your own family or even a family member.
____ Your child cries and seeks consolation even when his/her "injuries" appear trivial.
____ You have frequently observed themes of injury, harm, ambulance scenes, children needing help, bandages, operations, doctor/nurse play, or even death or dying situations in your child's fantasy play..
____ Your child's questions seem *unusually* suggestive of fears of death or illness.
____ Your child often complains of stomachaches, headaches, and a variety of vague painful sensations never clearly related to any illness..
____ Your child frequently asks you if he/she might be too sick to go to school, or reports feeling uncomfortable or "queasy" in the morning.
____ One or more family members frequently complains about disabling physical pain or a chronic illness.

If you feel your child had difficulties in any of these areas in the recent past, and they were very problematic until recently, please note with a X, XX, XXX and describe further below:

TEMPERAMENT RATING SCALES

DIRECTIONS: Parents: please rate your child or adolescent with a number from 0-4 on each one of the following items. 0= No problems, 1= Some or occasional problems, 2= Moderate or frequent problems, 3= Severe or very frequent problems, 4= Very severe or constant problems. Mark with an 'X' *especially severe problems*.

A Scale	B Scale
___Hyperactive, eager to please	___Hyperactive, testy, pouty
___Difficulty remembering directions	___Resists, resents directions
___Teases and provokes sibs, peers	___Physically aggressive with sibs/peers
___Usually playful, good mood	___Often nasty, angry, sour mood
___Forgets chores and tasks	___Rebels against chores and tasks
___Cries when frustrated	___Aggressive acting out when frustrated
___Struggles with homework	___Tears homework up, refuses to do it
___Easily bored	___Often creates chaos
___Pouts and cries when corrected	___Explodes when corrected
___Curious about sexual issues	___Precocious sexual acting out
___Depressed, dysthymic as teen	___Intense, nasty mood swings as pre-teen
___Argumentative as teen	___Suicidal vs explosive episodes as teen
___Socially immature for age	___Tries to act socially overmature
___Usually plays with younger children	___Hangs out with older children
___Total A score	___Total B score

A SCORE vs B SCORE RATIO:____/____

ADI DIAGNOSTIC QUESTIONS

Please rate your child or student in reference to these questions, using this scale:

4- Very consistently/frequently exhibits these behaviors
3- Usually "
2- Sometimes "
1- Rarely "
0- Never "

Please use the rating N/A if you have not had sufficient opportunity to evaluate some of these behaviors.

****

___Comes to you for comfort when hurt
___Comes to others for comfort when hurt
___Offers comfort to other children in distress (check here__if younger siblings only)
___Offers comfort to adults in distress (check here__if mother only)
___Greets other well-known peers, adults, and relatives with evident pleasure
___Actively seeks to share play and other activities with other___children or___adults
___SPONTANEOUSLY offers to share food, treats like candy, or toys with other kids
___Shows a very wide range of facial expressions typical for circumstances
___Is readily engaged ("caught up") in other childrens' excitement
___Accepts and returns affection from Mother
___Accepts and returns affection from most/other family members

___TOTAL SCORE AF Component

****

___Uses direct gaze and completely appropriate eye contact
___Maintains eye contact during conversation with others
___Eye contact appears similar to other children of the same age
___Spontaneously smiles in socially appropriate situations
___When touched or hugged by very familiar people, touches and huge back
___Directs others' attention to toys or other objects in which he/she has interests
___Asks about other childrens' interests ___Tries to share in their interests
___Understands and uses typical social gestures, such as waving "goodbye," shaking hands, nodding when in agreement, etc.

___TOTAL SCORE EJ Component

****

___Speaks with other children in attempt to be friendly
___Listens to other children while they speak, and uses gestures such as smiling or nodding to communicate he/she is “actively listening”
___Responds to the issues/concerens other children have introduced into the conversation
___Asks what/how other children think about things he/she has said
___Can usually recall and explain to a parent or other adult details about things which may be troubling other children
___Facial expression and voice clearly demonstrates concern or pleasure when discussing things learned from talking with other children

___TOTAL VJ Component

****

___Invents and or___plays social games with peers, e.g., tag, “Marco Polo,” etc.
___Imitates talk or actions of peers or relatives
___Engages in imaginative play___alone and/or___with peers
___Enjoys imaginative roles or costumes, e.g. at Halloween or in school plays
___Expresses interest and eagerness to make new friends
___Reports pleasure in activities with peers
___Has an especially close or “best” friend

___TOTAL TH Component

****

___Can accurately describe other people, including their special interests
___Can accurately describe how friends have different problems and interests than he/she has
___Chooses games or activities with the goal of involving peers, siblings, or parents
___Invites peers, siblings, or parents to join him/her in play
___Expresses pleasure when joined in play by peers, siblings, or parents
___”Shows off” or ___brags when very successful with a game or project
___Appears eager to please peers and adults other than his/her mother

___TOTAL OD SCORE

___TOTAL OF ALL SCORES

Name/role of person rating_____Date_____

MOOD, OBSESSION, COMPULSION, & TIC SYMPTOMS

This section is intended to be completed by PARENTS, CHILDREN, and TEENAGERS together – in the spirit of complete honesty between family members. Without exception, every single symptom or problem listed below RUNS IN FAMILIES! *Nobody* gets problems like these without their DNA being pre-programmed and SET to have them, and these are always - ALWAYS – problems that go 'way back, 'way, 'way back, generations back, like your DNA does, too!

It may not be possible, or practical, or even reasonable in some situations for *all* members of a family to attempt to complete this portion of the questionnaire together. I should emphasize that this is usually desirable, but it is not a "directive!" Parental discretion would be the final authority in the decision.

MOOD VARIATIONS

Please respond to the following questions using a scale of 0 – 5 , with 0 = Infrequent or Not Characteristic of your child, to 5 = Almost Always or Typical for your child, using 1-4 for intermediate ratings. Further, please note which family members *also* may have these characteristics by noting, in the margin, numbers and initials. For Mom or Dad, just use M or D. For siblings, use initials such as T. W. for a younger brother named Tommy Wallace, etc.

Patient Severity	Who Else	Age of Onset	
_____	_____	_____	Episodes of acting extremely irritable.
_____	_____	_____	"Mood swings" which seem unrelated to external events or stresses.
_____	_____	_____	"Mood swings" are remarkably severe, very high to very low.
_____	_____	_____	Outbursts of rage which seem unpredictable, and not due to some particular event
_____	_____	_____	Friends and family are increasingly concerned about unstable moods.
_____	_____	_____	Increasingly long periods of withdrawal from friends and family
_____	_____	_____	Loss of interest and participation in usual hobbies and activities.
_____	_____	_____	Grades and/or work productivity dropping substantially.
_____	_____	_____	History of suicide attempts ___ideas___ current suicidal ideas.
_____	_____	_____	Feeling like "giving up," "nothing left to lose."
_____	_____	_____	Episodes of wild, strange, bizarre ideas and actions.
_____	_____	_____	Negative, unhappy feelings that are persistent but never very deep.

OBSESSIONS

Patient Severity	Who Else	Age of Onset	
_____	____	_____	Preoccupation with contamination vs cleanliness themes.
_____	____	_____	Exaggerated need for order, exactitude, precision, things being lined up and even.
_____	_____	_____	Recurrent, *unwanted* thoughts which provoke guilt and anxiety.
_____	_____	_____	Odd, bizarre recurrent ideas or thoughts which may be *incredibly* weird, and extremely disturbing, involving morally unacceptable sexual or aggressive themes.
_____	_____	_____	Intense thoughts of this kind which cannot be "turned off" by any manner of personal psychological strategy.
_____	_____	_____	Thoughts or images which are so vivid, intense, and disturbing children and adolescents may feel they are "going crazy."
_____	_____	____	Anxiety and guilt over inability to control these symptoms is intense.

.

COMPULSIONS

_____	_____	____	Irresistible urges to do something to try to make disturbing obsessions go away.
_____	_____	_____	Cleaning taken to excessive lengths to try to defray fears of contamination by germs.
_____	_____	_____	Checking and re-checking to try to solve pathological doubt about everything being straight and neat and perfect.
_____	_____	____	Multiple erasures and changes to try to get everything EXACTLY PERFECT in all written work.

TICS

Tics are sudden, INVOLUNTARY, twitching movements, or brief, INVOLUNTARY noises. Tics may be vocal or motor, e.g. noises you hear, or movements you see. Common vocal tics include snorts, grunts, etc. Motor tics include blinking and nose twitching. Tics are usually familial (from your DNA). Please note below if your child has any of the following tics, severity on the familiar 0-5 scale, if any other family member has similar tics, and at what age your child developed each tic.

Patient Severity	Who Else	Age of onset		Patient Severity	Who Else	Age of Onset	
_____	_____	_____	Eye blinking	_____	_____	_____	Throat clearing
_____	_____	_____	Nose twitching	_____	_____	_____	Nasal sniffing
_____	_____	_____	Mouth twitching	_____	_____	_____	Snorting
_____	_____	_____	Neck jerking	_____	_____	_____	High-pitched noises
_____	_____	_____	Tongue thrusting	Other:_____			

COMPLEX TICS

Severity Who Age

_____ _____ _____Tongue or cheek biting
_____ _____ _____Shoulder jerks
_____ _____ _____Arm or leg jerks
_____ _____ _____Barking
_____ _____ _____Howling
_____ _____ _____Squeaking sounds
_____ _____ _____Obscene words blurted out in very unusual situations, clearly unintentional

SELF-INJURIOUS BEHAVIORS

Please rate these characteristics in the patient and family members using the 0 – 5 scales previously employed.

Severity Who Age

_____ _____ ____Substance or alcohol abuse problems are causing concern.
_____ _____ ____Someone in our family has a nasty secret.
_____ _____ ____Someone in this family sneakily pulls out scalp or other hair.
_____ _____ ____Patient or other family member cuts self on skin to “relieve tension.”
_____ _____ ____One of my family members picks and scratches skin “way beyond normal.”
_____ _____ ____Someone in my family is in DEEP, DEEP TROUBLE due to gambling.
_____ _____ ____Someone in my family is in legal trouble.
_____ _____ ____Someone in my family REALLY needs medical attention NOW! Why?

OTHER: Yes___No___ Are any loaded weapons kept in your home?
Yes___No___ Do any visiting relatives or friends disrupt the family environment?
Yes___No___ Would you describe the family environment as tense?

GOOD THINGS ABOUT OUR FAMILY

So far, all these questions have asked about problems! But *that* is not a complete portrait of your family (or mine, either, thank goodness)! Now, please write a brief summary of the REALLY GOOD THINGS about your family:

KIDS SECTION: THE FOLLOWING QUESTIONNAIRES ARE FOR THE CHILD OR ADOLESCENT TO COMPLETE.

CAMSS

Child and Adolescent Mood Scales – By Robert A Kowatch
A.D.D. Clinic, Inc. Revised Edition

This questionnaire is to be answered by the child or adolescent.

This form is about how you have been feeling recently – for about the last week or two. Here is how to use this form:

0= No problem 1= Just a little trouble 2= Serious trouble 3= Major big problem

Got the idea? OK, here are the important things. Circle how you feel.

1) I feel like I can't control myself very well.	0	1	2	3
2) I feel like my thoughts are going too fast.	0	1	2	3
3) I have LOTS of energy.	0	1	2	3
4) I feel "speedy" or "hyper" inside.	0	1	2	3
5) I feel very good.	0	1	2	3
6) I feel pretty sad and depressed.	0	1	2	3
7) It seems like nothing will work out for me	0	1	2	3
8) I often feel like crying.	0	1	2	3
9) Everything and everybody bugs me	0	1	2	3
10) I have been *really mad* recently	0	1	2	3
11) I have lots of UP and DOWN moods.	0	1	2	3
12) I am really angry at someone in my family	0	1	2	3

KID'S QUESTIONNAIRE

DIRECTIONS: Parents should ask older children and teenagers to complete this questionnaire themselves whenever possible, checking to make sure it is finished before the first interview. Parents should assist younger children with the questionnaire, but please make sure answers to the questions are the child's own responses. Parents may choose to comment on these responses in the margins! OLDER CHILDREN and TEENAGERS should tear off the last page of this questionnaire, fill it out PRIVATELY, and give it to the Doctor or Counselor during the first meeting without showing it to anyone else.

Hi, my name is _____. I am ____; I will be ____ on my next birthday,

which will be _____. I go to _____ School, where I am in ____ Grade.

(If it is summer, what grade are you going into in the Fall? _____)

There are ____ other kids in my family. Here are their names and ages:

Name _____ Age ____ Brother_____Sister_____

Name _____ Age ____ Brother_____Sister_____

Name _____ Age ____ Brother_____Sister_____

Name _____ Age ____ Brother_____Sister_____
Anyone else?

I live with my: Mom ___ Dad ___ Both ___ Mom and Step-Dad ___ Aunt ___Uncle____
Dad and Step-Mom ___ Grandmother ___ Grandfather____Grandparents ___ Other ___

My regular doctor's name is _____. I don't have one ___.

My family and I are members of the_____church.

We go to church:___regularly___almost every weekend___sometimes___rarely___never

FOR ALL THE FOLLOWING QUESTIONS, PLEASE ANSWER USING THIS CODE:
Y – when this is usually true
S- when this is sometimes true
N- when this is never true

SCHOOL

___ I make dumb mistakes in my homework
___ I often feel scared at school
___ Kids tease me a LOT at school
___ I act wild and crazy at school
___ I have 'way too much homework
___ I get sent to the Principal a lot
___ I don't "work up to my potential"
___ I fall asleep during class
___ I can't use school bathrooms
___ I act like a clown in class
___ Teachers usually do not like me
___ I forget to turn my homework in
___ I really hate school this year
___ I get bullied a LOT at school
___ I like my teacher (or teachers)
___ I daydream a lot during class
___ I feel too rushed all day at school
___ I am worried about my grades

MOOD

___ I can't control myself very well
___ I feel pretty sad a lot
___ Other kids seem to dislike me
___ I feel very shy
___ Nothing I do seems to be good enough
___ I always feel incredibly angry
___ I think God hates me
___ I have very nasty thoughts
___ I don't' worry about things often
___ I am usually pretty happy
___ I kind of avoid responsibility
___ I spend a lot of time worrying
___ I don't like my self very much
___ I'm ashamed of things I have done
___ I have thought about killing myself
___ I can't cope anymore
___ I am the Ultimate Nerd
___ I feel really strange
___ I get angry easily
___ I get over being angry quickly

HEALTH

FIRST: <u>BAD NEWS</u>: We do not have any needles, syringes, or "shots" anywhere in the A.D.D. Clinic! We know all kids will be very disappointed to hear this, but we hope – somehow – you will be able to manage! **SECOND:** Please answer these health questions carefully and honestly. Use a **Y** if the answer is **YES**, a **N** if the answer is **NO**, and a **SO** is the best answer is **SOMETIMES OR SORT OF.**

___ I have a lot of headaches
___ I wet the bed sometimes
___ I am not growing as fast as I should
___ My heart feels like it pounds funny
___ I am 'way too thin
___ I worry I should have started puberty by now but I don't think I have yet
___ Kids tease me for looking different
___ I can't see what the teacher writes on the blackboard when I am at the back of the class
___ I have a lot of stomachaches
___ I have pains in my legs and knees
___ I am 'way too fat
___ I breathe hard when I run
___ I want to lose more weight
___ Something is wrong with part of my body
___ I can't stop pulling out hairs
___ I get sick to my stomach a lot during school, especially after lunch or during recess

___ I wake up with terrible nightmares often
___ My asthma is getting worse
___ I think I have started puberty
___ I am not as strong as other kids my age
___ (Girls) I have started to have “periods”
___ I CAN’T settle down and get to sleep when I know I should
___ I am having bowel problems
___ I don’t feel well-coordinated
___ My chest hurts when I run
___ Acne is driving me CRAZY!

PLEASE WRITE IN YOUR OWN ANSWERS:

When I grow up, I want to be _____

I really enjoy playing _____

I get angry when I have to_____

My best subject in school is _____

My worst subject in school is _____

I wish I had a big _____

I wish I had a little _____

I wish I were the only kid _____

Sometimes, I get really afraid of _____

I wish I could be turned into a _____

THREE WISHES:

You get 3 wishes, no more. GO FOR IT:

1)_____

2)_____

3)_____

PRIVATE QUESTIONS

A parent or older sibling(s) should, of course, help young children complete this part of the questionnaire.

This is the page we suggest older children and teenagers tear off, complete privately, and give to the doctor or counselor without showing parents *unless the kids choose to do so.* Answer with **Y**+ for Super Yes, **Y** for Yes, **S** for Sort of, **N** for No.

___ Mom understands how I feel
___ I have AWFUL THOUGHTS that really bother me
___ I mess up sometimes on purpose
___ I have REALLY WEIRD ideas
___ Sometimes I do bad things to get back at somebody in my family
___ I know I need to see a counselor
___ Doctors totally scare me

___ Dad understands how I feel
___ Somebody I live with is really mean to me
___ I believe in God
___ I don't like one of my family members
___ I have a secret problem my parents don't know about
___ I do not like counselors
___ I am kind of going crazy

****

___ There is something I have to talk with you about privately.

___ Please do not insist I see a counselor or therapist; I can't handle that right now!

___ Please do not insist I must have a complete physical examination right away; I can't handle that now, since I know "complete" = "embarrassing."

___ Please do not order lab work with blood tests! I am incredibly scared of needles!

___ I am *really scared* about taking medicine! (If yes, why?)

___ I have had some bad experiences with other: ___ doctors___or counselors___or both!

___ I enjoy going to church

Please write a few words about what is bothering you the most:

PLEASE FINISH THIS STORY, IF YOU WOULD LIKE TO:
OPTIONAL

It is a bright, sunny Saturday morning in July. 22 boys and girls and their 5 counselors from the Green River Parks & Recreation Club start their hike up Lookout Mountain. Everyone is well-prepared with a backpack containing a snack and lunch, two liters of water, a compass, a flashlight, and a jacket in case of rain). Just when they come to Chief Red Feather's Pass, about 10:30 AM, a tremendous storm suddenly sweeps in from the West! The counselors can't hear or see all the kids since it is so dark and rain is coming down so hard, so lots of kids get lost deep in the woods.

Two hours later three kids, Tommy (11), Eric (9), and Andrea (12) find themselves huddled in the same small cave: The rain is letting up, but it is still very dark, cold, and the wind is LOUD and nasty! Tommy's left ankle hurts terribly. He is trying not to cry, but the pain is awful. Tommy, Eric, and Andrea are all freezing cold and soaking wet. They talk over what to do, and: _____