**Healthy Roots Pediatrics**
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# ADHD Initial Evaluation Packet

Your provider recommends your child be evaluated for attention deficit hyperactivity disorder (ADHD). Thoughtful completion of this packet is very important in starting this evaluation process.

Upon completion and return of this packet, you will be asked to schedule a visit to review the results with your provider. At this visit, your provider will go over his/her assessment with you and recommendations for next steps. Next steps may include requesting accommodations or further evaluation by the school system, referring to a mental health provider and/or discussing potential medication management. Please note, this visit may not be scheduled for 4-6 weeks AFTER receiving the entire packet, depending on provider schedules.

As several diagnoses can mimic symptoms of ADHD, such as anxiety, depression, and learning disabilities, your provider may recommend pursuing an evaluation for an alternative diagnosis after review of this packet.

If you are interested in pursuing medication management AND your provider recommends medication management for your child, you are required to schedule medication checks AT LEAST every 3 months. ADHD medications are not refilled over the phone, and failure to attend medication rechecks may result in interruption of or termination of prescription. We also require a "Medication Contract" be signed for prescribing of controlled substances.

If you are interested in more information about ADHD, below are several good resources:

- www.healthychildren.org
- www.CHADD.org
- www.cdc.gov/ncbddd/adhd/

**Patient Name:** _____

**Patient DOB:** _____

**Birth History:**

Gestational age (circle): Term / Preterm

If Preterm/premature, how many weeks? _____

Any pregnancy or birth complications (circle)? Yes / No

If yes, please briefly describe: _____

_____

**Developmental History:**

Did your child receive birth to three services or early intervention such as speech, occupational therapy, or physical therapy? Yes / No

If yes, what services? _____

At what age did your child start daycare and/or preschool? _____

Were there any concerns in daycare/preschool? Yes / No

If yes, what concerns? _____

_____

**Social history:**

Who lives in your child's home(s)? _____

_____

Have there been any major changes in your child's life in the past year? Yes / No

If yes, what kind of changes? _____

_____

Are there any current stressors in your child's life? Yes / No

If yes, what stressors? _____

_____

Is your child involved in any organized activities such as sports or clubs? Yes / No

Does your child currently work with a mental health professional such as a therapist, counselor or psychologist? Yes / No

**Family history:**

Is there a family history of any of the following? Please circle for "yes" and comment on relation to child (i.e. mother, father, sister, paternal aunt, etc)

ADHD/ADD _____

Anxiety _____

Arrhythmias (irregular heart rhythm) _____

Autism _____

Bipolar disorder _____

Depression _____

Learning Disabilities _____

Substance Abuse/Addiction _____

Schizophrenia _____

Obsessive-Compulsive Disorder (OCD) _____

Oppositional Defiant Disorder (ODD) or Conduct Disorder _____

Tic disorder _____

Seizure disorder or epilepsy _____

**Medical History:**

Does your child have any medical problems/diagnoses? Yes / No

If yes, what medical diagnoses? _____

_____

Does your child take any medications, vitamins, or supplements? Yes / No

If yes, please list _____

_____

_____

**Education:**

Where does your child attend school? _____

What grade is your child in? _____

Does your child receive any supports or services in school? Yes / No

Does your child have a 504 plan or IEP? Yes / No

Do you have any concerns about your child's academic progress? Yes / No

If yes, what are your concerns? _____

_____

_____

Has your child's teacher expressed any concerns? Yes / No

If yes, what concerns? _____

_____

_____

Do you have any additional comments, questions or concerns that you want to address?

_____

_____

_____

_____

**Medication Contract**

**Patient Name**: _____

**Patient DOB**: _____

I understand that stimulant medication is being prescribed for my child _____.
The purpose of this contract is to ensure safe and effective use.

I agree to the following:

1. The medication is prescribed for my child's use and my child's use only.
2. I will schedule medication rechecks every 3 months. I understand that missed appointments may result in interruption or cancellation of my child's prescription.
3. The medication is to be stored in a safe and secure place.
4. Any changes in dosing needs to be discussed with the prescribing provider.
5. I understand that lost/stolen medication will not be replaced.
6. I understand that stimulant medication will not be refilled over the phone.

Parent/Guardian Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____