ADI Health Parent Questionnaire

(Required for All Patients Of/Under the Age of 19)

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1214 W. Northwest Hwy., Palatine, IL 60067
Phone: 847-577-7705
Fax: 847-929-9138
Email: support@adi.health

Please download and complete this Parent Questionnaire for new patients under the age of 18. The information provided in this Questionnaire will be used by your provider to guide the initial evaluation and assist with the potential diagnosis and/or resulting treatment plan for the patient.

This form must be completed to the best of your ability and submitted with all accompanying attachments and / or requested documentation at least 48 hours prior to your first appointment with Dr. Sharma and/or Dr. Fallor via your OnPatient Account or via fax to the number above.

Thank you for your cooperation!

IDENTIFYING/DEMOGRAPHIC INFORMATION

Child's First & Last Name _____

Child's Nickname _____

Child's Date of Birth _____ **Age** _____ **Grade**_____

Gender (select one) ☐ F ☐ M Other _____

Handedness ☐ L ☐ R Other _____

Ethnicity_____

Child's Primary Address _____

_____

_____

Home Phone Number _____

Primary Cell Phone Number _____

School _____

Who does the child live with _____

Languages spoken at home _____

Is child adopted? ☐ Yes ☐ No

If yes, at what age was he/she adopted? _____

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FAMILY INFORMATION

Primary Family Member Information

First & Last Name _____

Mobile Number _____

Work Number _____

Email Address _____

Relationship to Patient / Child? ☐ Mothe ☐ Fathe ☐ Guardian ☐ Other_____

Education/Occupation _____

Secondary Family Member Information

First & Last Name _____

Mobile Number _____

Work Number _____

Email Address _____

Relationship to Patient / Child? ☐ Moth ☐ Fath ☐ Guardia ☐ Other_____

Education/Occupation _____

Marital Status of Listed Family Members (please circle all that apply)

Primary Family Member ☐ Singl ☐ Marrie ☐ Divorce ☐ Remarrie ☐ Other_____

Secondary Family Member ☐ Singl ☐ Marrie ☐ Divorce ☐ Remarrie ☐ Other_____

If the parents are divorced, is there a court-enforced parenting agreement in place? ☐ Ye ☐ No

If there is a court-enforced, parenting agreement in place, please email this document to jamie@adi.health

Who does the child live with? ☐ Moth ☐ Fath ☐ Bot ☐ Other_____

Who has legal custody of the child ☐ Moth ☐ Fathe ☐ Guardia ☐ Other_____

If you wish me to contact the parent with whom the child is not living, please give his/her name and address _____

Please list all adults and children who have regular contact with your child:

Name	Age	Relationship to Child	Living in Same Household?	
			Yes	No

Is there any additional information that you would like to share regarding the minor's living situation/household(s)?

_____

_____

_____

_____

_____

Emergency Contact

Please provide the name and contact information for someone who is NOT the parent/guardian in case of an emergency

First & Last Name _____

Mobile Number _____

Work Number _____

Email Address _____

Relationship to Patient / Child?_____

Have you submitted a Release of Information (ROI) for your emergency contact? ☐ Yes ☐ No

If you answered no to this question, please complete a ROI and email it to jamie@adi.health

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REFERRAL & PROVIDER INFORMATION

Who referred you to our service?

Name _____

Profession/Relationship_____

Address _____

Phone Number _____ Email _____

Fax Number _____

Child's Primary Care Physician (PCP)

Name _____

Address _____

Phone Number _____ Email _____

Fax Number _____

Have you completed a Release of Information for our office to contact this provider? ☐ Yes ☐ No*

Other Provider Information

Name _____

Profession/Relationship_____

Address _____

Phone Number _____ Email _____

Fax Number _____

Have you completed a Release of Information for our office to contact this provider? ☐ Yes ☐ No*

**If you have not submitted ROI's for any of the above listed parties and would like us to be in contact with them to ensure alignment of care, please refer to the new patient email for this form and complete/return copies for all relevant parties/providers to our office (jamie@adi.health) at your earliest convenience.*

REASON FOR REFERRAL

Briefly state the main concerns for which you are presently seeking help for the patient / your child.

_____

_____

_____

_____

_____

What kind of information and/or assistance are you hoping to obtain for the patient / your child? What are your treatment goals?

_____

_____

_____

_____

_____

Does your child have any school and/or home behavior problems? ☐ Yes ☐ No

If yes, please describe / explain further.

_____

_____

_____

_____

_____

Does the patient / your child have any school/learning problems? ☐ Yes ☐ No

If yes, please describe / explain further.

_____

_____

_____

_____

_____

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Please list any/all social problems that the patient / your child may have with peers of adults (e.g. bullied, teased, no friends, poor social skills, aggressive, bossy, shy, etc.).

_____

_____

_____

_____

_____

Please describe any other problems / areas that the patient / your child may have that may be of relevance to this evaluation.

_____

_____

_____

_____

_____

Please describe two or three of the patient's / your child's strengths.

_____

_____

_____

_____

_____

Please describe two or three of the patient's / your child's weaknesses.

_____

_____

_____

_____

_____

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Please list all past neurological, psychiatric, psychological, neuropsychological, educational, speech & language, or other types of evaluations administered to your child. (Indicate where, when, and by whom these were done).

Evaluated at **By** **On**

_____

_____

_____

_____

_____

Please attach and send copies of these reports with this form to jamie@adi.health

Please list all present or past interventions, treatment, or remediation the child has received or is receiving, including Physical Therapy, Occupational Therapy, Speech and Language Therapy, Psychotherapy, etc. (Indicate where, when, and by whom these were done):

Received at **By** **On**

_____

_____

_____

_____

_____

Please attach and send copies of these reports with this form to jamie@adi.health

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PREGNANCY AND BIRTH HISTORY

Length of pregnancy (months) _____

Total number of weeks of pregnancy_____

Was the patient / child's delivery early or late? _____

Birth Weight _____ **lbs** _____ **oz**

Number of Days in Hospital _____

Apgar Score (if known) _____

Did the patient / your child require help to breathe when delivered? ☐ Yes ☐ No

Type of delivery (circle all that apply)

☐ Vagina ☐ Breec ☐ Cesarea ☐ Forcep ☐ Aided

Newborn difficulties (circle all that apply)

☐ Non ☐ Cyanosis (Turned Blue ☐ NIC ☐ Other: _____

Describe any known difficulties in conception and/or complications that occurred during pregnancy.

_____

_____

_____

_____

_____

Were any medications used during pregnancy? ☐ Yes ☐ No

If yes, what kind?

_____

_____

_____

_____

_____

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Were alcohol, drugs, tobacco, or other substances used during pregnancy? ☐ Yes ☐ No

If yes, describe frequency and type.

_____

_____

_____

_____

_____

Complications during labor or delivery? ☐ Yes ☐ No

If yes, please describe

_____

_____

_____

_____

_____

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DEVELOPMENT (INFANCY)

As an infant, did the patient / your child show any eating or sleeping problems?

_____

_____

_____

_____

_____

How would you describe the temperament of the patient / your child as an infant?

_____

_____

_____

_____

_____

Did the patient / your child have any noteworthy issues during infancy?

_____

_____

_____

_____

_____

Developmental Problems	Describe Problem
Speech/Language	_____
Sleeping	_____
Toileting	_____
Tics/Twitches	_____
Nail Biting/Thumb Sucking	_____
Grinding Teeth	_____
Head Banging/Rocking	_____
Impulsivity	_____
Aggressive Behavior	_____
Temper Tantrums	_____
Anxiety/Fear/Worries	_____
Depression/Sadness/Crying	_____

DEVELOPMENTAL MILESTONES

Domain	Milestone	Age	Problems if any?
Motor	Sat without support		
	Crawled		
	Walked		
	Toilet Trained		
Language	Spoke first words		
	Put 2-3 words together		
	Spoke in Sentences		
Play	Played with dolls/stuffed animals		
	Pretend/imaginative play		
	Played in cooperation w/others		

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MEDICAL HISTORY

Domain	Select One		Age	Describe
	Yes	No		
Allergies				
Appetite/Eating Problems				
Clumsiness/Poor Motor Skills				
Ear Infections/tube				
Chromosomal Abnormality				
Headaches				
Hearing/Ear Problems				
Loss of Consciousness/Head injury				
Nightmares				
Persistent High Fevers				
Physical Disabilities				
Surgeries				
Sleep Apnea/Snoring				
Seizures				
Vision/Eye Problems				
Alcohol Use/Abuse				
Illicit Drug Use/Abuse				
Risky Behaviors				

Please add any additional information / concerns regarding the patient / your child's medical history.

_____

_____

_____

_____

_____

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What is the present illness and/or concern for which the patient / your child is being treated and/ or for which you are seeing treatment?

_____

_____

_____

_____

_____

Notable childhood diseases other than current illness (specify age and any complications).

_____

_____

_____

_____

_____

Hospitalizations (medical or psychiatric; specify age and provide details).

_____

_____

_____

_____

_____

Are there any other issues and/or concerns that you have re: the patient's / your child's health?

_____

_____

_____

_____

_____

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CURRENT / PAST MEDICATIONS

Name of Medication	Dosage & Quantity	Date Prescribed?	Prescribing Physician

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FAMILY HISTORY

Please outline and describe any / all family history of medical problems.

_____

_____

_____

_____

_____

Please outline and describe any / all family history of attention/learning problems.

_____

_____

_____

_____

_____

Please outline and describe any / all family history of emotional/behavioral/psychiatric problems.

_____

_____

_____

_____

_____

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EDUCATION HISTORY

Day Care

Does or did your child attend daycare before preschool? ☐ Yes ☐ No

Name/Location _____ **Ages** _____

Any problems? _____

Preschool

Does or did your child attend preschool? ☐ Yes ☐ No

Name/Location _____ **Ages** _____

Any problems? _____

Kindergarten

Does or did your child attend kindergarten? ☐ Yes ☐ No

Name/Location _____ **Ages** _____

Any problems? _____

Elementary/High School

List names and locations of schools attended

_____ **Grades**_____

_____ **Grades**_____

_____ **Grades**_____

_____ **Grades**_____

_____ **Grades**_____

Name and address of current school:

_____

_____

Telephone # _____ **Teacher's Name** _____

Have you completed a Release of Information for our office to contact this provider? ☐ Yes ☐ No*

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Please indicate the following, if applicable:

Age child entered 1st grade _____

Was the patient / your child held back / retained a grade, and if so, when and why?

_____

_____

Has the patient / your child ever skipped a grade in school? If yes, when and why?

_____

_____

Has the patient / your child ever received detention, been suspended, or expelled?

_____

_____

Does or has the patient / your child ever received any special education, enrichment, or resource service?

_____

_____

Has the patient / your child had services rendered under an IEP or 504 Plan? Please explain.

_____

_____

**Please email copies of all relevant school reports including formal IEP or 504 Plans to jamie@adi.health*

	Select One		Age	Describe
	Yes	No		
Early Education Intervention	☐	☐		
Occupational Therapy	☐	☐		
Physical Therapy	☐	☐		
Speech Therapy	☐	☐		
Social Work	☐	☐		

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STRESSFUL EVENTS

Do any of the following stressful events that apply to your child or family? If so, please describe.

Relocations _____

Job Change _____

Death(s) _____

Illnesses _____

Marital Problems _____

Traumatic Events _____

Physical/Sexual Abuse or Neglect _____

Legal Issues _____

Other _____

ADDITIONAL INFORMATION

Please add any additional remarks you may wish to make regarding your child. Thank you for taking the time to complete this form.

_____

_____

_____

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_____

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ADHD RATING SCARE – IV

Home Version

Circle the number that ***best describes*** your child's behavior over the past **6 months** (or since the beginning of the school year).

	Rarely (0)	Sometimes (1)	Often (2)	Very Often (3)
1. Fails to give close attention to details or makes careless mistakes in school work				
2. Fidgets with hands or feet or squirms in seat				
3. Has difficulty sustaining attention in tasks or play activities				
4. Leaves seat in classroom or in other situations in which remaining seated is expected				
5. Does not seem to listen when spoken to directly				
6. Runs about or climbs excessively in situations in which it is inappropriate				
7. Does not follow through on instructionsand fails to finish work				
8. Has difficulty playing or engaging in leisure activities quietly				
9. Has difficulty organizing tasks and activities				
10. Is 'on the go' or acts as if 'driven by a motor'				
11. Avoids tasks (e.g. schoolwork, homework) that requires sustained mental effort				
12. Talks excessively				
13. Loses things necessary for tasks or activities				
14. Blurts out answers before questions have been completed				
15. Is easily distracted				
16. Has difficulty awaiting turn				
17. Is forgetful in daily activities				
18. Interrupts or intrudes on others				

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