

Provincial ADHD Program

Clinical Care, Training & Research of Attention Deficit Hyperactivity Disorder (ADHD) in Children, Adolescents and Adults

Clinic location:

Children's & Women's Health Centre of BC
Room B425A - Shaughnessy Building
4500 Oak Street, Vancouver, BC

Mailing address:

Provincial ADHD Program
Box #178 – 4500 Oak Street
Vancouver, BC V6H 3N1

Phone: 604-875-3551

Clinic Fax: 604-875-2870

Email: adhd@cw.bc.ca

Research Fax: 604-875-2468

FAMILY HISTORY QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____ Today's date: ___/___/___

Person completing this form: _____ Relation to the patient: _____

This form allows us to get information you might only have at home, or which you might feel uncomfortable talking about in the interview. *Please let the secretary or doctor know if you need to be seen alone, with your partner or if you feel your child needs to be seen alone.* If you are uncomfortable or unsure of any of the items on this form leave them blank.

School Name		Grade
Private school		Public School
Child's 1 st language		
<u>Mother</u>		<u>Father</u>
Name		Name
Age		Age
Occupation		Occupation
Final level of Education		Final level of education
Relationship to child	Birth parent	Foster
	Adoptive	Other
	Step	
Marital status	Single ___ Separated ___ Divorced ___ Common law ___ Married ___ Remarried ___	
Age, gender of other offspring		
Custody	Mother ___ Father ___ Joint ___	
	Is the other biological parent aware of the request for this assessment? Yes No	
# children at home		
# people in home		
Other Caregivers		
Extended health insurance	Yes	No
Does your extended health insurance cover medications not covered by pharmacare?		
Does your extended health insurance cover psychological treatment? Are there restrictions?		

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Has this child and/or the family been exposed to any trauma (physical abuse, sexual abuse, emotional abuse, involved in an accident or other serious event)? NO YES Don't Know

Please describe:

Has the child's mother and/or father ever been abused?

Please list all of your child's medications below and **bring the bottles with you:**

MEDICATION(S) (and/or herbal therapies)

Medication Name			
Who prescribed			
When started			
When stopped			
For What Problem(s)			
Dose			
Benefits			
Side Effects			
End Results			

During the pregnancy with this child did the biological mother

Substance	When in the pregnancy?	How often?	How much?
Cigarettes			
Alcohol			
Marijuana			
Street drugs			
Medications			

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Is there anything else you would like us to know about this child/family before we meet together?

Please check off the boxes that indicate problems in other family members:

Problems with:	Child's mother	Child's father	Sister or brother				Other Close
Aggression							
Attention							
Hyperactivity and/or impulsivity							
Learning at school							
Mental retardation							
Psychosis or schizophrenia							
Depression							
Suicide							
Anxiety							
Motor or vocal "tics"							
Alcohol							
Marijuana							
Other drugs							
Physical abuse							
Sexual abuse							
Hospitalized for emotional problems							
Heart problems							
Seizures							
Other (please specify)							