



**ADHD DIRECT HOME ASSESSMENT PROFORMA**

PATIENT NAME..... DOB.....

COMPLETED BY.....AND.....

NAME OF OTHER(S) COMPLETING FORM AND RELATIONSHIP TO PATIENT.....

IDEALLY, THIS PROFORMA SHOULD BE COMPLETED BY THE PERSON BEING ASSESSED (WHO WILL BE REFERRED TO AS THE "PATIENT") AND BY PARENTS/RELATIVE OR PARTNER.

QUESTIONS WITH A **RED X** SHOULD BE COMPLETED BY PARENT(S)/RELATIVE OR PARTNER. QUESTIONS WITH A **GREEN X** SHOULD BE COMPLETED BY THE PATIENT.

QUESTIONS WITH A **RED X** OR **GREEN X** SHOULD BE COMPLETED EITHER PARENT(S)/RELATIVE/CARER OR PATIENT

**FAMILY COMPOSITION**

1. **X** IS THE PATIENT YOUR:  BIOLOGICAL CHILD  
 ADOPTED CHILD OR FOSTER CHILD  
 OTHER (please state).....

2. **X X** WHO ALL LIVES WITH THE PATIENT? PLEASE GIVE DETAILS OF EVERYONE LIVING AT HOME INCLUDING NAMES AND AGES OF SIBLINGS OR ANY OTHER CHILDREN IN THE FAMILY:

4. **X X** IF THE PATIENT'S PARENTS ARE SEPERATED, PLEASE GIVE DETAILS OF THE CIRCUMSTANCES OF THE SEPARATION AND ANY CURRENT CONTACT BETWEEN PARENTS AND PATIENT:

5. **X** DOES THE PATIENT CURRENTLY WORK? YES  NO   
(please give details)

6. **X X** PLEASE GIVE DETAILS OF YOUR EMPLOYMENT HISTORY:

7. **X X** DO THOSE LIVING AT HOME GET ON WELL WITH ONE ANOTHER?  
(please give details)

YES  NO

**FAMILY BACKGROUND CONTINUED**

(If you answer YES, to any of the following please give details)

8. **X X** ARE THERE ANY FACTORS THAT MAY BE CONTRIBUTING TO FAMILY STRESS? YES  NO

9. **X X** ARE THERE ANY HEALTH CONCERNS IN THE FAMILY?

YES  NO

10. **X X** HAVE ANY OTHER FAMILY MEMBERS e.g. GRANDPARENTS, COMMENTED ON THE PATIENT'S BEHAVIOUR EITHER IN THE PAST OR PRESENT? YES  NO

11. **X X** ARE THERE MANY ARGUMENTS OR A LOT OF SHOUTING AT HOME? YES  NO

12. **X X** DO YOU KNOW OF ANY OTHER FAMILY MEMBERS WHO HAVE DIFFICULTIES WITH ATTENTION AND/OR HYPERACTIVITY? YES  NO

USE THE TABLE BELOW TO INDICATE ANY FAMILY HISTORY OF MENTAL HEALTH OR LEARNING DIFFICULTIES BY PUTTING A TICK IN THE APPROPRIATE COLUMN FOR EACH EXAMPLE, AND NOTING THE RELATIONSHIP TO THE CHILD **X X**

COMPLAINT	A PROBLM ✓	RELATION TO PATIENT
AGGRESIVENESS, DEFIANCE		
DIFFICULTIES WITH ATTENTION		
LEARNING PROBLEMS		
FAILED TO ATTEND SCHOOL		
PSYCHOSIS/SCHIZOPHRENIA		
DEPRESSION		
ANXIETY		
TICS OR TOURETTES SYNDROME		
ALCOHOL/SUBSTANCE ABUSE		
ANTISOCIAL BEHAVIOUR		
ARRESTS		
PHYSICAL/SEXUAL ABUSE		

**DIET**

1. **X** DESCRIBE YOUR APPETITE:

2. **X** WHAT DO YOU EAT OVER THE COURSE OF THE DAY?

3. **X X** HAVE THERE EVER BEEN ANY PROBLEMS WITH BEHAVIOUR AROUND MEAL TIMES, EITHER AS A CHILD OR AT PRESENT e.g. ARE THEY ABLE TO SIT AT THE TABLE/ DO THEY RUSH FOOD OR TAKE AN AGE TO FINISH?

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**SLEEP PATTERN:**

1. **X** TIME TO BED:

TIME TO SLEEP:

2. **X X** HAS THE PATIENT EVER HAD PROBLEMS SLEEPING RIGHT THROUGH THE NIGHT?

YES  NO

(if YES, please give details)

3. **X X** HAS THE PATIENT EVER REPORTED BAD DREAMS?

YES  NO

(if YES, please give details)

4. **X X** HAS BED WETTING EVER BEEN A PROBLEM FOR THE PATIENT?

YES  NO

(if YES, please give details)

5. **X X** TIME AWAKE:

WOKEN BY:

6. **X X** HOW WELL DOES THE PATIENT ORGANISE THEMSELF IN THE MORNING BOTH NOW AND AS A CHILD i.e. HOW LONG DO THEY TAKE, DO THEY NEED HELP etc?

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**MEDICAL HISTORY:** IF THE PATIENT'S MEDICAL HISTORY INCLUDES ANY OF THE FOLLOWING PLEASE INDICATE THEIR AGE AT THE TIME AND ANY RELEVANT INFORMATION. **X X**

<b>HISTORY</b>	<b>AGE</b>	<b>DETAILS</b>
CHILDHOOD ILLNESS		
OPERATIONS		
HOSPITALIZATIONS		
HEAD INJURIES		
SEIZURES		
COMA		
EYE PROBLEMS		
ALLERGIES OR ASTHMA		
POISONING		
SLEEP PROBLEMS		
APPETITE PROBLEMS		
GROWTH PROBLEMS		

CURRENT HEIGHT:

CURRENT WEIGHT:

IS THE PATIENT TAKING ANY MEDICATION?  
(if YES, please give details)

YES  NO

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3. WAS THE MOTHER RELAXED/COMFORTABLE SEPARATING FROM THE BABY?:

4. WAS THE BABY HAPPY TO SEPARATE FROM THE MOTHER/WAS IT HAPPY TO BE PUT DOWN?:

5. WHERE DID THE BABY SLEEP TO BEGIN WITH?:

6. DID THE MOTHER OF THE PATIENT SUFFER FROM BABY-BLUES/POST-NATAL DEPRESSION?:

**EARLY TEMPRAMENT X X**

1. WAS THE PATIENT AN EASY SOCIABLE BABY?

2. DID THEY SETTLE INTO GOOD ROUTINES AS A BABY?

3. ANY PROBLEMS WITH SLEEP, FEEDING OR CRYING?



**DEVELOPMENTAL MILESTONES X X**

PLEASE INDICATE AT WHAT DID THE PATIENT ACHIEVE THE FOLLOWING DEVELOPMENTAL MILESTONES OR IF THERE WERE ANY DIFFICULTIES.

<b>MILESTONE</b>	<b>AGE</b>	<b>CURRENT DIFFICULTIES</b>
SMILED		
SAT UNSUPPORTED		
CRAWLED		
STOOD UNSUPPORTED		
SPOKE FIRST WORDS		
SAID PHRASES		
SAID SENTENCES		
DRY ALL DAY		
DRY ALL NIGHT		
BOWEL TRAINED		
RODE TRICYCLE		
RODE BICYCLE WITHOUT STABILISERS		
BUTTONED CLOTHING		
TIED SHOELACES		
CAUGHT A BALL		
NAMED COLOURS		
SAYING THE ALPHABET		
BEGAN TO READ		
BEGAN TO WRITE		

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**EDUCATION HISTORY: X X**

1. DID THE PATIENT ATTEND NURSERY? YES  NO

IF YES, AT WHAT AGE DID THEY ATTEND:

2. WERE ANY CONCERNS RAISED AT THAT TIME? YES  NO

3. WHAT PRIMARY AND SECONDARY SCHOOLS DID THEY ATTEND?.....

4. DO WE HAVE PERMISSION TO CONTACT THE SCHOOL(S)? YES  NO

**SCHOOL CONCERNS:**

5. DO YOU FEEL THAT THE SCHOOL(S) KEPT THE PATIENT'S PARENT'S INFORMED REGARDING CONCERNS THEY HAD ABOUT THE PATIENT? YES  NO

6. INDICATE IF SCHOOLS EVER DESCRIBED ANY OF THE FOLLOWING AS SIGNIFICANT CLASSROOM PROBLEMS:

BEHAVIOUR	NOT A PROBLEM ✓	A PROBLEM ✓
DOESN'T SIT STILL IN HIS OR HER SEAT		
FREQUENTLY GETS UP AND WALKS AROUND THE CLASS		
SHOUTS OUT. DOES NOT WAIT TURN TO ANSWER		
DOES NOT COOPERATE WELL IN GROUP ACTIVITIES		
TYPICALLY DOES BETTER IN A ONE-ONE SITUATION		
DOES NOT RESPECT THE RIGHTS OF OTHERS		
DOES NOT PAY ATTENTION DURING LESSON		
FAILS TO FINISH CLASSWORK		
FAILS TO FINISH HOMEWORK		
BULLIES OTHER CHILDREN		
IS NOT SOUGHT BY OTHER CHILDREN FOR WORK OR PLAY		

7. HAS SCHOOL EVER EXPRESSED CONCERNS IN ANY OF THE FOLLOWING AREAS:

LEARNING (give details)

**SCHOOL CONCERNS CONTINUED:**

8. BEHAVIOUR (give details)

9. RELATIONSHIPS WITH OTHER CHILDREN (give details)

10. WERE THE PARENTS/CARERS OF THE PATIENT EVER ASKED TO COLLECT THEM BEFORE THE  
END OF THE SCHOOL DAY BECAUSE OF THEIR BEHAVIOUR? YES  NO

11. IF YES, APPROXIMATELY HOW OFTEN DID THIS OCCUR?.....

12. WAS THE PATIENT EVER EXCLUDED FROM SCHOOL? YES  NO

IF YES, WHY, HOW OFTEN AND FOR HOW LONG?

13. WHAT DID EDUCATION DO TO TRY AND HELP THE PATIENT?

14. DID THE PATIENT EVER SEE AN EDUCATIONAL PSYCHOLOGIST? YES  NO

IF SO WHO AND WHAT FOR?.....

15. DID THE PATIENT EVER GET ANY LEARNING SUPPORT? YES  NO

**DAILY SITUATIONS X X**

DESCRIBE THE PATIENT'S BEHAVIOUR IN THE FOLLOWING SITUATIONS BOTH NOW AND AS A CHILD:

1. MORNING ROUTINE:

2. OUT SHOPPING:

3. IN THE CAR / ON THE BUS:

4. IN A RESTAURANT (MCDONALDS):

5. CINEMA / THEATRE:

6. PARTIES/CHRISTMAS:

7. SWIMMING:

8. HAIRDRESSERS/BARBERS:

9. DOES THE PATIENT LACK A SENSE OF AWARENESS IN DANGEROUS SITUATIONS

YES  NO

e.g. CROSSING THE ROAD?

IF YES, PLEASE GIVE EXAMPLES

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