Scarano & Taylor Pediatrics

Joseph Scarano, MD FAAP ***A. Florentina Taylor, MD FAAP***

Parent Attention/Behavior Questionnaire

Student's Name _____ Date of Birth _____
Form Completed By _____ Today's Date_____

BEHAVIOR	MOST OF THE TIME	OFTEN	SOMETIMES	NEVER
Does not pay close attention to details or often makes careless mistakes on school work, at work and during other activities.				
Has difficulty paying attention when completing tasks or while playing.				
Does not listen when others are speaking to him/her.				
Has difficulty following through on instructions and does not complete schoolwork, chores or workplace duties.				
Is disorganized.				
Dislikes or avoids tasks that require sustained attention or mental effort (such as class work or homework).				
Loses things necessary for tasks or activities (such as books, personal items or homework assignments).				
Is easily distracted.				
Is forgetful in daily activities.				

Parkwood Professional Center
4861 27th Street West, Bradenton, FL 34207
941-755-0800

BEHAVIOR	MOST OF THE TIME	OFTEN	SOMETIMES	NEVER
Fidgets with or taps hands or feet or squirms in seat.				
Leaves seat when remaining seated is expected (such as in classroom or workplace)				
Runs and climbs (in situations where it is inappropriate or is restless.				
Has difficulty playing or working quietly.				
Is “on the go” as if driven by a motor.				
Talks excessively.				
Blurts out answers before a question has been completed.				
Has difficulty waiting his/her turn.				
Interrupts or intrudes on others (e.g. butts in or uses others things without permission)				
Is sad and tearful.				
Is overly focused on certain thoughts or ideas.				
Repeats certain actions or rituals excessively (e.g. handwashing, arranging objects).				
Is aggressive towards others or gets into fights.				
Intentionally breaks things or destroys others property.				
Ignores authorities and gets into trouble.				
Is anxious or nervous.				

How old was your child when you first noticed these problems? _____

My child's difficulties are evident at (**check all that apply**):

☐ School ☐ Home ☐ Other (specify) _____

In which areas do you feel your child's difficulties affect him/her (**check all that apply**)?

☐ Academics ☐ Social Interaction ☐ Self Esteem ☐ Family Life

☐ Other (specify) _____

Has your child ever been diagnosed with, or treated for a neurologic, developmental, behavioral or mental disorder? ☐ Yes ☐ No If yes, please specify: _____

Does your child have a learning disorder or dyslexia? ☐ Yes ☐ No

Does your child have any nervous habits such as eye blinking, throat clearing, twirling hair, making sounds or twitching? ☐ Yes ☐ No

Have any immediate family members been diagnosed with, or treated for, mental illness, psychologic/psychiatric disorder, emotional disturbance, attention deficit disorder or learning disability? ☐ Yes ☐ No If yes, please list family members and diagnoses: