ATTENTION DEFICIT DISORDER QUESTIONNAIRE
(COMPLETE ALL QUESTIONS)

Name of primary applicant: ______________________________________ ID/SSN: _________________________

Name of person treated / relationship to applicant: ____

Please answer all questions pertaining to the person for which the condition applies. Please circle appropriate condition, test and/or treatment where applicable. If you need assistance in completing this form, please contact your physician. If there is a charge for completing this form, it will be at your expense.

1. Date first treated: ____
2. Please state the names, dosages and frequency for taking any medications prescribed:

   ____

   ____
3. Is medication still being taken? ___ Yes ___ No. If no, when was medication discontinued? ______________
4. Is medication taken throughout the year, or are there "breaks" during school vacation?

   Please give details: ____
5. Have there been any behavioral problems at school, truancy, etc? ___ yes ___ no

   If yes, please provide details: ____
6. Any growth problems or other mental/physical problems noted? ___ Yes ___ No

   If yes, please provide details: ____
7. Has the child received psychological counseling, or has counseling been recommended? ___ Yes ___ No.

   If yes, please provide details (including dates of treatment and name, address and phone number of counselor, physician or therapist): ____

   ____

   ____
8. Have there been any hospitalizations for this or other related conditions? ___ Yes ___No. If yes, please give details: ____

   Date of confinement: ____________ Length of stay: ______________________________

   Name, address and phone number of hospital where confined: ______________________

   ____
9. Are you still being treated? ___ Yes ___ No. If no, indicate date released from doctor. ______________

   If yes, indicate date you are to be released: ____________________________________
10. Name, address and phone number of treating physician or health care practitioner:

   ____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

____ _________________________

Signature of person treated (or parent/guardian if under 18) Date

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