



**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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