

Attention Deficit Hyperactivity Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. Circle the diagnosis made by the physician: Attention Deficit Hyperactivity

2. When was the diagnosis made? Age _____ Date _____

3. Medication to control condition Dosage Frequency

In regard to children; is this medication taken year-round, or only during the school year?

4. Has there been improvement as a result of the medication? _____

5. Any psychological counseling required? Yes or No

If so, when did it begin? _____ Frequency of visits? _____

How much longer to continue, if known? _____

6. Any hospitalization required? Yes or No If so, when? _____

Where? _____ How Long? _____

7. What has the Doctor told you about prognosis of condition? _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

