Demographic/Medical Questionnaire

Participant ID:

_____

Date:

_____

1. My child is: ◯ Male ◯ Female ◯ Other

Please explain 'Other'

_____

2. What is your child's date of birth?

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December
(Month)

Date of Birth Year

_____
(Year)

Date of Birth

_____

3. Does your child have any siblings (brothers or sisters with the same mother and father as the child) taking part in this study?: ◯ No ◯ Yes

If yes, how many siblings?

_____

4. What is your relationship with the child?

◯ Biological Mother
◯ Biological Father
◯ Adoptive Mother
◯ Adoptive Father
◯ Grandparent
◯ Stepmother
◯ Stepfather
◯ Legal Guardian

If Legal Guardian was selected please specify (e.g., foster parent, etc.)

_____

5. Please indicate whether your child has ever had a diagnosis of or treatment for:

- ☐ Head injury
- ☐ Hearing problems
- ☐ Premature birth
- ☐ ADHD, ADD
- ☐ ODD
- ☐ Stroke
- ☐ Cardiac arrhythmia
- ☐ Congenital Heart Defect (CHD)
- ☐ Schizophrenia, manic depression, bipolar disorder, anxiety disorder, depression
- ☐ Obsessive-Compulsive Disorder
- ☐ Tics
- ☐ Substance abuse (alcoholism, illicit drug use)
- ☐ Seizures, convulsions
- ☐ ASD (Autism, Aspergers, PDD)
- ☐ Other
- ☐ None

Other, please specify: _____

Head Injury

How old was your child at the time of the head injury? _____

Units ◯ Years ◯ Months

Did your child lose consciousness for more than 30 minutes? ◯ No ◯ Yes

Did your child have any of the following problems immediately after his/her head injury?

Vomiting, nausea, dizziness, double vision, confusion about where he/she was, confusion about who he/she was, confusion about what time it was, dazed, foggy, slow to respond, tired or weak, confusion, sleepiness, asked questions over and over

◯ No ◯ Yes

Was your child admitted overnight to the hospital? ◯ No ◯ Yes

6. Does your child receive any special care in any of the following? ◯ No ◯ Yes

If yes, please specify:

- ☐ Gifted
- ☐ English as a second language
- ☐ Resource room
- ☐ Special education
- ☐ Private/independent school
- ☐ Home schooled
- ☐ After school homework club
- ☐ Learning disability
- ☐ Language impairment
- ☐ Behavioural problems or ADHD
- ☐ Individualized education program (IEP)
- ☐ Resource teacher
- ☐ Student support program
- ☐ Personal support worker

7. Has your child ever had a diagnosis of or treatment for any learning problems? ◯ No ◯ Yes

8. Are you and/or your child currently participating in:

☐ Individual Therapy ☐ Family Therapy ☐ Parent Training ☐ None of these

9. Is your child currently taking any prescribed medication? ◯ No ◯ Yes

Stimulant ADHD Medication:

☐ Adderall (Amphetamine and Dextroamphetamine)
☐ Ritalin (Methylphenidate)
☐ Ritalin SR (Methylphenidate)
☐ Concerta (Methylphenidate)
☐ Biphentin (Methylphenidate)
☐ Dexedrine (Dextroamphetamine)
☐ Dexedrine Spansules (Dextroamphetamine)
☐ Vyvanse (Lisdexamfetamine dimesylate)

Non-stimulant ADHD medication:

☐ Strattera (Atomoxetine)
☐ Intuniv (Guanfacine)
☐ Clonidine

☐ Risperdal (Risperidone)
☐ Seroquel (Quetiapine)
☐ Zyprexa (Olanzapine)
☐ Zeldox (Ziprasidone)
☐ Invega (Paliperidone)
☐ Abilify (Aripiprazole)
☐ Clozaril (Clozapine)
☐ Prozac (fluoxetine)
☐ Paxil (Paroxetine)
☐ Luvox (Fluvoxamine)
☐ Celexa (Citalopram)
☐ Cipralex (Escitalopram)
☐ Zoloft (Sertraline)
☐ Anafranil (Clomipramine)
☐ Wellbutrin (Bupropion)
☐ Zyban (Bupropion)
☐ Lithium

☐ Other

Other - Please specify: _____

10. Has your child taken any stimulant medication(s) within the past 24 hours? ◯ No ◯ Yes

11. Does your child play videogames? ◯ No ◯ Yes

If yes, how often does he/she play in a week?	◯ Never ◯ Once a week ◯ 2/3 times a week ◯ 4/5 times a week ◯ Every day
What category of games does he/she play the most?	☐ Puzzle based games ☐ Sports ☐ Educational ☐ Battle ☐ Strategy / Problem solving ☐ Action / Adventure ☐ Other
Other, please specify	_____
Please name the video games you play most often.	_____

** Please remember not to disclose your child's randomization status (the treatment group he/she is assigned) to your child's teacher, or anyone performing assessments during the study visits at SickKids. This is a blinded study which means that we would like certain individuals not knowing the study treatment your child is receiving in order to get unbiased study results.