focusMD

Please return this paperwork to our office in person, by US Mail, or secure fax:
Focus-MD Tuscaloosa
720 Energy Center Blvd, Suite 504
Northport, AL 35473
Phone: 205-301-2837 Fax: 877-794-2293

Patient Information

First:_____ Middle:_ _____ Last Name: _____

Nickname: "_____" DOB ____ / ____ / _____ Gender: *Female / Male* SS#_____

Mailing Address: _____ City: _____ State: ____ Zip: _____

School/Employer: _____

Preferred Email: _____ May we use emails for appointment reminders, health news, or practice notices? ☐ Yes ☐ No

Preferred Phone Number: (_____) _____ - _____ ☐ *home* ☐ *cell* *May we send text reminders to this number?* ☐ Yes ☐ No

Alternate Phone Number: (_____) _____ - _____ ☐ *home* ☐ *cell* *May we send text reminders to this number?* ☐ Yes ☐ No

How did you hear about Focus-MD? ☐ Doctor Referral ☐ Another Focus-MD office ☐ Internet Search/Google
☐ Another patient ☐ Friend/Relative ☐ Sign/Drove by ☐ Facebook ☐ Internet ad ☐ Other ad _____

Guarantor Information: ***(****person responsible for paying for this patient account)*

First:_____ Middle:_ _____ Last Name: _____

Relationship to patient: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Cell #: : (_____) _____ - _____ School/Employer:_____

Primary Insurance Information

Insurance Carrier: _____ ID #:_____ Group #: _____

Policy Holder's Name: _____ DOB: ___ / ____ / _____ Relationship to patient: _____

Pharmacy BIN # : _____ *Is there a separate card for prescriptions?* ☐ Yes ☐ No

Secondary Insurance Information

Insurance Carrier: _____ ID #:_____ Group #: _____

Policy Holder's Name: _____ DOB: ___ / ____ / _____ Relationship to patient: _____

Pharmacy BIN # : _____ *Is there a separate card for prescriptions?* ☐ Yes ☐ No

Primary Care Physician

Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Referring Medical Professional ***(If applicable – referral not required to schedule an appointment unless mandated by insurance)***

Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Preferred Pharmacy

Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

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Financial Policy

This financial policy contains important information about payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to payment for services.

Please note: The party that brings the child to the office will be responsible for the visit's copay AND will also be the final responsible party on record. We will not be involved in parental court cases. Whoever brings the child to the office for a visit will be considered as authorized to receive financial and medical information and to make medical decisions. Information regarding a visit will be available on the portal.

It is the patient's responsibility to make payment at the time of service for all services rendered if it is determined that the patient's insurance policy may not cover our services. You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. The contract with your insurance company mandates that we collect copays at this time. The credit card on file may be billed for the copay, deductible, outstanding balance, and other fees that are due. *(Please see Credit Card Policy for details.)* If a patient finds that they will be unable to pay in full upon at the time of service, they will be responsible for determining a payment plan agreed upon by Focus-MD *prior to the scheduled appointment*.

Additional Fees

No Show/Late Cancellation Extended Appointments	**$100**	Extensive Letters or Accommodation Requests	**$25**
No Show/Late Cancellation Follow-Up Appointments	**$50**	Medical Records **$5** search fee	
Returned Check	**$35**	+ **$1**/page up to 25 pages + **$0.50**/page 26+ pages	

We require a 24 hour advance notice for cancellations or reschedule. Less than 24 hours is considered as a "No Show". As a courtesy, you may receive a reminder of your upcoming appointment by phone or text message. You are still responsible for honoring your appointment even if you do not receive such a reminder. Unless other arrangements are made in advance, the parent or guardian of patients less than 18 years of age will be responsible for payment according to the terms described above.

Students, 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent/guardian or themselves. For those students whose parent / guardian(s) will maintain responsibility for payment, an authorization for services must be signed by that parent or guardian. As a convenience, the parent / guardian will be asked provide a credit card number and authorize that the co-pay be billed to that card at each visit.

You, the patient, have a contract with your insurance carrier. Our services may or may not be covered by your particular policy. It is your responsibility to contact your carrier to determine if these are covered services under your contract ***prior*** to the date of service. A referral may be required by your insurance company for services to be paid. It is the ***patient's responsibility*** to obtain the required referral for treatment prior to the visit. Without this referral, you may be held responsible for the full charges occurred.

Our staff is happy to help with general questions relating to a claim or to provide additional information requested by your insurance carrier in order for the claim to be processed. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department by calling the number on the back of the card.

For each visit please bring:
Current insurance card and Driver's License
Co-pay/Deductible for the day's visit (this is an estimate from our billing dept.)
Cash, check, or credit card for paying any balance from previous billing.

By my signature below, I acknowledge that I have read, understand, and agree to abide by the Focus-MD Financial Policy.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

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Name of patient: _____ **Date of birth:** ____ / ____ / _____

We welcome you to our practice and look forward to helping you and/or your family member manage the attention / learning problems and the associated conditions that you face. Our aim is to provide the very best of care and to see tremendous positive changes in the life of each patient.

In our contracts with health insurance carriers, we are obligated to collect co-pays and deductibles at the time services are rendered. If a form of payment is not brought to an appointment, it may need to be rescheduled.

As part of our financial understanding with our patients and families, we are securely saving a credit card number in each patient's electronic record. For those families who have medical saving accounts, we can store the number associated with this account in addition to a credit card. This serves as a measure of convenience for the patient and family to be used for any applicable co-payment, deductible, or outstanding balance owed. This will also prevent the need to reschedule. This should benefit students who have a parent of other family member serving as guarantor.

In order to provide optimal care for our patients, we schedule sizable blocks of time for each patient visit. This makes it necessary for us to charge a no-show fee for appointments not canceled at least 24 hours before the appointment time. Accordingly, the credit card may also be used to cover any charges not covered by insurance, such as no-show fees.

Occasionally, the insurance carrier will assign a portion of the bill to the patient after the date of service. We may also use the credit card on file to cover the balance owed.

Our pledge to you: We will seek to disclose the charges that are being made to the patient or guarantor in advance. In no case will we bill your credit card for amounts in excess of $100 without such notification. We also give you assurance that data entered into the electronic health record system, including financial information, is not stored on-site, but is transmitted with encryption to highly secured "cloud" servers which house our records.

We greatly appreciate your understanding concerning this policy. We will be happy to discuss with you any questions or concerns that you may have regarding this or any of our financial policies.

I, _____ *(printed name), acknowledge I understand and will abide by the Tuscaloosa Focus-MD credit card policy.*

Guarantor Signature _____ Date **:** ____ / ____ / _____

CREDIT CARD:

Name as listed on credit card: _____ **Last 4 digits of credit card:** _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Preferred Phone # (_____) _____ - _____ ☐ *home* ☐ *cell* Alternate Phone # (_____) _____ - _____ ☐ *home* ☐ *cell*

MEDICAL SAVINGS ACCOUNT:

Name as listed on MSA card: _____ **Last 4 digits of credit card:** _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Preferred Phone # (_____) _____ - _____ ☐ *home* ☐ *cell* Alternate Phone # (_____) _____ - _____ ☐ *home* ☐ *cell*

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Non-Covered Service Policy

As our patients, we want to provide you the best care possible. There may be certain services that we feel are necessary that are not covered by some insurance carriers.

- You will be expected to pay for those services in full at the time they are provided.
- Policy holders of insurance carriers other than those currently contracted with our Providers will be expected to pay in full at the time of service.

These procedures are frequently used by Focus-MD providers and may or may not be covered under your insurance policy.

New Patient Testing *(May or may not be covered under insurance)*	***Testing/Assessment Codes***
• QbTest	96120 & 96119
• Clinicom	96103
• Behavior Rating Scales *(e.g. Vanderbilt Assessments, Barkley Adult ADHD Rating Scales, Barkley Deficits in Executive Functioning Rating Scales, ADHD Rating Scale IV, Patient Health Questionnaire-9, etc.)*	96127

Attention Cigna and Coventry Patients:

One or more of the following Focus-MD testing procedures is not being covered by Cigna nor Coventry. At this time, Cigna and Coventry do not pay for any type of neuropsychological testing for ADHD or related disorders. Focus-MD has contacted Cigna and Coventry in an effort to educate them on the value and evidence base for the testing we provide. Unfortunately, Cigna and Coventry require providers to have this waiver signed each time the testing is performed. If you have questions or concerns about Cigna and Coventry's policy please call the customer service number listed on your insurance card.

By my signature below, I acknowledge that I have read and understand that charges for services not covered by my insurance plan will be my responsibility to pay in full the day the services are rendered.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

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Authorization for Release of Medical Information

Patients Name _____ DOB: ___/___/_____ SSN:_____

Address: _____ City _____ State _____

Zip Code_____ Phone Number (_____) _____ - _____ Date of Request ___/___/___

Focus-MD Tuscaloosa
720 Energy Center Blvd, Suite 504
Northport, AL 35473
Phone: 205-301-2837 Fax: 877-794-2293

☐ I authorize Focus-MD **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Focus-MD **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) ☐ Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐ Personal use ☐ Attorney/Legal ☐ Continued Care (Consult/Referral)

TYPE OF RECORDS TO BE RELEASED or OBTAINED (check one)

____ Complete medical record
____ Summary of records (including problem lists, dates & detailed summary of all visits, growth chart, allergies, & medication list)
____ Office Notes only
____ All Items checked below (select one or more, as applicable)
☐ Procedure Reports ☐ History & Physical Examinations ☐ Psychological & Educational Testing Results
☐ Medication List ☐ Medical/Psychiatric Office Notes ☐ Behavioral Rating Scales ☐ Other *(please list below)*

AUTHORIZATION VALID FOR THE FOLLOWING DATES OF SERVICE: (Check one):

☐ Records pertaining only to treatment received on date of this request.
☐ Records pertaining to treatment received on or prior to the date of this authorization
☐ Records pertaining to treatment received on or prior to AND for one year from the date of this authorization.
☐ Records pertaining to all previous treatment and of any **future** treatment of the type described above until ____/____/____ *(date)*

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.

Signature of Patient or Representative_____ Date: ___/___/___

Relationship to Patient _____

Witness Signature: _____ Date: ___/___/___

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called **Protected Health Information** (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

_____ (initial)

Your rights regarding your Protected Health Information (PHI):

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy:

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site. Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Focus-MD.* If you have questions and would like additional information, you may contact your office.

Focus-MD
Attn: Privacy Officer
PO Box 88061
Mobile, AL 36606

_____ (initial)

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CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

With my consent, Focus-MD, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Focus-MD, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be requested.

I have the right to request that Focus-MD restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Focus-MD, use and disclosure of my PHI to carry out TPO.

With my consent, Focus-MD may call, at the numbers provided, my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, billing information and any call pertaining to my clinical care, including laboratory results, treatment plans, condition updates among others. With my consent Focus-MD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Focus-MD may decline to provide treatment to me.

I have received and understand the NOTICE OF PRIVACY PRACTICES.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

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Patient Acknowledgement of Privacy, Financial, and Practice Policies

Financial Policies

_____ (initial) I acknowledge I have received the Focus-MD **Financial Policy**

- Patient/guarantor is responsible for providing accurate insurance information
- Patient/guarantor is responsible for any authorization required by insurance companies
- Patient/guarantor understands additional fees may incur as described in policy

_____ (initial) I acknowledge I have received the Focus-MD **Credit Card Policy**

- The office will keep a credit card number on file to use for charging co-pays, deductibles, balances assigned by insurance and other fees.

_____ (initial) I acknowledge I have received the Focus-MD **Non-Covered Service Agreement**

- Some services are not covered by insurance
- Any services not covered are the responsibility of the patient/guarantor

_____ (initial) Our **Cancellation Policy**

Our provider's time is reserved for you. We do not double book our patients in order to provide adequate time for each individual. We strive for exceptional care through individual attention.

- Any appointment cancelled *less than 24 hours in advance* is considered a No Show.
- A No Show will result in a $100 fee on a new or extended patient appointment and $50 on an established patient appointment. This fee is not covered by insurance.
- Exceptions to this policy will be reserved for verifiable emergencies only at the sole discretion of management.
- As few as 3 repeated No Show appointments may result in unconditional discharge from care at this facility.

Privacy Polices

_____ (initial) I acknowledge I have received the Focus-MD's **Notice of Privacy Practices**

- Our Notice of Privacy Practices provides information about how we use and disclose your PHI

_____ (initial) I acknowledge I have received the **Consent of Use or Disclosure of PHI**

We will not discuss your or your child's care with family or friend unless authorized in writing.

Please complete the following so that the individuals you specify can have access to your information.

I consent to disclosure of the following protected health information about my child/me to the following family member(s) or person(s) involved in the care or payment for my child's/my care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- In accordance with the law, your protected health information may be disclosed by us to effectively treat you, to receive payment from your insurance company for your care, and to effectively operate our office.
- Our office may send appointment reminders or other health care information via phone, voicemail, text or mail.

_____ (initial) To ensure privacy, I agree to use the patient portal for questions pertaining to medical management and discussion of symptoms/side effects. I understand that this communication becomes part of the patient's medical record.

_____ (initial) I authorize Focus-MD to access my prescription history (including dosage & refills) from online pharmacy databases.

_____ (initial) I authorize Focus-MD to correspond with and/or release my medical records to my Primary Care Physician and Referring Provider

I have read and understand the policies and procedures listed above.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

Patient Name: _____

REVIEW OF SYSTEMS:

Constitutional

☐ Yes ☐ No Daytime Drowsiness (*despite adequate sleep)*
☐ Yes ☐ No Dulled Personality
☐ Yes ☐ No Excessively Fatigue *(tiring easily)*
☐ Yes ☐ No Nightmares / Night Terrors
☐ Yes ☐ No Problems Falling Asleep
☐ Yes ☐ No Problems Staying Asleep *(frequently awakening)*
☐ Yes ☐ No Sleep Walking
☐ Yes ☐ No Talking During Sleep

Head

☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Migraines

Eyes

☐ Yes ☐ No Having Prescription for Glasses or Contacts
☐ Yes ☐ No Vision Problems

Ears/Nose/Throat

☐ Yes ☐ No Dry Mouth
☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Large Tonsils
☐ Yes ☐ No Snoring

Respiratory

☐ Yes ☐ No Cough at Night / Wakes Patient
☐ Yes ☐ No Frequent Cough
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Tightness in Chest

Heart/Vascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Fainting
☐ Yes ☐ No Heart Racing / Fast Heart Rate
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Palpitations / Heart Skipping Beats

Gastrointestinal

☐ Yes ☐ No Constipation
☐ Yes ☐ No Decreased / Poor Appetite
☐ Yes ☐ No Decreased Appetite at Lunch
☐ Yes ☐ No Frequent Abdominal Pain
☐ Yes ☐ No GERD / Reflux / Frequent Heartburn
☐ Yes ☐ No Picky Eater
☐ Yes ☐ No Stool Leakage / Accidents

Genito/Urinary

☐ Yes ☐ No Bed Wetting
☐ Yes ☐ No Daytime Urinary Accidents / Incontinence
☐ Yes ☐ No Frequent Urination
☐ Yes ☐ No Irregular, Heavy Period
☐ Yes ☐ No Recently Missed Periods *(amennorhea)*
☐ Yes ☐ No Significant Menstrual Cramping / Pain

Skin/Hair/Nails

☐ Yes ☐ No Acne
☐ Yes ☐ No Dry Skin
☐ Yes ☐ No Eczema
☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Rashes
☐ Yes ☐ No Twirls or Pull Hair/Picks at Skin, Nails

Neurological

☐ Yes ☐ No Motor Tics (Involuntary)
(ex: blinking, jerking, grimacing)
☐ Yes ☐ No Seizures
☐ Yes ☐ No Tremor (Hand Shaking Involuntarily)
☐ Yes ☐ No Verbal Tics (Involuntary)
(ex: sniffing, throat clearing, vocalizing)

Musculoskeletal

☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Limp or Gait Disturbance
☐ Yes ☐ No Recent Injury
☐ Yes ☐ No Restricted Motion

Endocrine

☐ Yes ☐ No Feeling Excessively Hot *(heat intolerance)*
☐ Yes ☐ No Feeling Excessively Cold *(cold intolerance)*
☐ Yes ☐ No Recent Weight Gain
☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Problems with Growth/Short Stature
☐ Yes ☐ No Sweating Excessively
☐ Yes ☐ No Thyroid Problems

Heme/Lymph

☐ Yes ☐ No Anemia
☐ Yes ☐ No Easily Bruised

Allergic/Immunologic

☐ Yes ☐ No Allergies
☐ Yes ☐ No Asthma
☐ Yes ☐ No Food Allergy (list _____)

Psychiatric

☐ Yes ☐ No Aggression
☐ Yes ☐ No Anger Outbursts, frequent or explosive
☐ Yes ☐ No Anhedonia *(unable to have fun)*
☐ Yes ☐ No Anxiety / Worries Excessively *(in general)*
☐ Yes ☐ No Anxiety Excessive in Social Situations
☐ Yes ☐ No Cutting Behavior / Self Injury *(not suicidal)*
☐ Yes ☐ No Depressed, Sad *(most of time)*
☐ Yes ☐ No Flat Effect / Zombie-like
☐ Yes ☐ No Irritable / Easily Annoyed / Touchy
☐ Yes ☐ No Hallucinations *(hears/sees things others don't)*
☐ Yes ☐ No Low Self Esteem
☐ Yes ☐ No Manic Episode *(no sleep x ≥ 24 hrs w/o fatigue, feeling of having special abilities, super-productive)*
☐ Yes ☐ No Mood Issues Related to Menstruation
☐ Yes ☐ No Mood Swings *(frequent/abrupt/large mood changes)*
☐ Yes ☐ No Obsessive Compulsive Behaviors
☐ Yes ☐ No Overly Confident or Grandiose
☐ Yes ☐ No Paranoid *(thinks others intend harm)*
☐ Yes ☐ No Rigid, Inflexible Thought Patterns
☐ Yes ☐ No Sensory Issues *(ex: Hates Tags, Loud Noises, Problems with Food Textures)*
☐ Yes ☐ No Suicidal Actions *(making plan/attempt to harm self)*
☐ Yes ☐ No Thoughts of Self Harm, Suicide

Adolescent and Child History Form

Patient's Name: _____ **Preferred name**: "_____" **Today's Date**: ___ / ___ / ___

Birth Date: ___ / ___ / ___ **Age**: ____ years **Gender**: ☐ Male ☐ Female

Home Address: _____
street *city* *state* *zipcode*

Mother's Home Phone: ( ) ____ - _____ **Mother's Cell / work Phone**: ( ) ____ - _____

Father's Home Phone: ( ) ____ - _____ **Father's Cell / work Phone**: ( ) ____ - _____

When at home with family, patient is presently living with the following people *(check all that apply)* :

☐ natural mother ☐ natural father ☐ stepmother ☐ stepfather ☐ grandmother ☐ grandfather
☐ adoptive mother ☐ adoptive father ☐ foster mother ☐ foster father ☐ splits time between 2 homes
☐ sisters (#) ____ ☐ brothers (#) ___ ☐ others *(please specify)* _____

Current school: _____ **Grade level:** _____ **School Performance**: *As Bs Cs Ds Fs*

Reasons for Consultation - Please list your current concerns in order of highest priority first. Please give a complete statement of your concerns and those expressed by teachers and other significant adults in patient's life..

a. _____

b. _____

c. _____

d. _____

e. _____

In which settings are these behavioral concerns affecting patient?

Home School Social Sports / Extra-curricular activities Other (please list)

When did the concerns listed in the last two questions begin?

Does patient get along well with other children of similar age? **YES** **NO**

Does patient have a number of friends with whom they enjoy playing? **YES** **NO**

Please list all after-school activities in which patient participate including athletic, artistic, & social organizations.

Please list patient's other special interests.

Please list patient's strengths and positive traits.

Has patient ever been diagnosed with ADHD in the past? **NO** **YES** *(please list previous MD below and give further details on p.3)*

Previous MD for ADHD Care: _____ **Address:** _____

Current Primary Care MD: _____ **Address:** _____

Patient's Medical History

1. Has patient had any of the following?

Problem	No	Yes	If yes, please describe and give age(s) of occurrence
Arrhythmia *(Heart racing or skipping beats)*			
Heart murmur			
Other Heart abnormality or disease			
Chest pain			
Syncope *(passing out)*			
Hypertension *(high blood pressure)*			
Thyroid disease			
Seizures (convulsions)			
Migraine Headaches			
Allergies *(food, pollens, dust, etc)*			
Asthma *(wheezing, exercise induced asthma)*			
Tics (involuntary vocalization, jerking of head, face or arms)			
Broken bones or other **serious injury**			
Sleep disorder (sleep apnea, narcolepsy, restless leg syndrome)			
Any other serious illnesses			
Medication Allergies or Intolerance			

2. Has patient had to stay overnight in the hospital? ☐ NO ☐ YES If yes, please give reason for admission and age.

3. Has patient ever had any surgery? ☐ NO ☐ YES *If yes, please give procedure and age.*

4. Has patient ever experienced any Concussion or Head injuries? ☐ NO ☐ YES *If yes, please describe including length of time of any loss of consciousness, feeling dazed, visual changes, memory loss, headaches, difficulty concentrating, or other lingering symptoms.*

5. How is patient's vision? ☐ Normal ☐ Vision impairment ☐ Wears eyeglasses or contacts ☐ Other _____

6. How is patient's hearing? ☐ Normal ☐ Some hearing impairment ☐ Uses hearing aid ☐ Other _____

Present Medical Condition

1. Is patient being treated for any physical illnesses? ☐ No ☐ Yes *(please list):* _____

2. Is patient taking any medications currently? ☐ No ☐ Yes *(please list and give doses):*

_____

3. Please indicate which of the following the patient has experienced in the past 6 months.

	No	Yes
Excessive sweating		
Undesired weight loss		
Feeling excessively hot		
Frequent bowel movements		
Difficulty sleeping		

	No	Yes
Dry skin		
Undesired weight gain		
Feeling excessively cold		
Constipation		
Excessive fatigue		

Behavioral Health History

1. Has patient ever been diagnosed with ADHD in the past? NO YES If yes, at what age? _____

Who made the diagnosis? ☐ Psychologist ☐ Pediatrician ☐Family MD ☐Psychiatrist ☐Other _____

How was the diagnosis made?
- ☐ Interview by physician without testing
- ☐ Referral to psychologist
- ☐ Checklists completed by parents
- ☐ Checklists completed by teachers
- ☐ Checklist completed by patient
- ☐ Computerized testing
- ☐ Psychological testing
- ☐ Other _____

Did the patient ever see a psychologist for psychological and/or educational testing? NO YES

2. Please list the medications patient have received in the past for ADHD

Name & dosage of medication	Patient's age(s) while taking this	Was it effective in treating ADHD?	What side effects did patient have while taking this medication?	Why did patient stop taking this medication?
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		

3. Has patient ever been diagnosed with any other emotional / behavioral health *conditions*? NO YES

➢ If yes, which conditions? ☐ Depression ☐ Bipolar disorder ☐ Anxiety disorder ☐ Social anxiety ☐ Panic attacks ☐ Obsessive-compulsive disorder ☐ Motor tics (short sudden repetitive movements such as blinking, face muscle twitching, head / neck jerking) ☐Verbal tics (throat clearing, repeated words) ☐ Other _____

4. Which other emotional / behavioral health medications *(such as antidepressants or mood stabilizers)* **has patient taken?**

Name & dosage of medication	Patient's age(s) while taking this	Was it effective in treating condition?	What side effects did patient have while taking this medication?	Why did patient stop taking this medication?
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		
		No Somewhat Yes		

5. Which of the following issues have been experienced frequently by patient?

- ☐ argues with adults
- ☐ temper outbursts
- ☐ actively defies adults
- ☐ deliberately annoys others
- ☐ shifts blame
- ☐ excessive worry
- ☐ fearful/anxious
- ☐ depressed mood
- ☐ appearing excessively tired
- ☐ somnolence
- ☐ trouble sleeping
- ☐ obsessive thinking
- ☐ counts/arranges objects
- ☐ always does things in order
- ☐ rechecks things excessively
- ☐ is easily annoyed/touchy
- ☐ angry/resentful
- ☐ spiteful/wants to get even
- ☐ bullies/threatens/intimidates
- ☐ starts physical fights
- ☐ afraid to try new things
- ☐ panic symptoms
- ☐ significant weight loss
- ☐ significant weight gain
- ☐ feeling lonely
- ☐ feeling empty / worthless
- ☐ needs to know everything
- ☐ needs to tell everything heard
- ☐ rigid / black & white thinking
- ☐ lies to avoid responsibility
- ☐ skips school
- ☐ physically cruel
- ☐ stolen things of value
- ☐ destroyed property of others
- ☐ separation anxiety
- ☐ performance anxiety
- ☐ feeling guilty
- ☐ thoughts of death
- ☐ suicidal thoughts (w/o a plan)
- ☐ suicidal thoughts (with plan)
- ☐ dislikes certain textures / sounds
- ☐ picking at skin & nails
- ☐ pulls own hair excessively
- ☐ has used a weapon
- ☐ has broken in
- ☐ stayed out all night
- ☐ ran away
- ☐ forced sexual activity
- ☐ social anxiety
- ☐ specific phobias / fears
- ☐ irritability
- ☐ rages / meltdowns
- ☐ claims to have "superpowers"
- ☐ manic / hypomanic episodes
- ☐ erases and redoes schoolwork
- ☐ needs symmetric arrangement
- ☐ avoids certain numbers

Birth History

1. **Were there any pregnancy complications?** ☐ No ☐ Yes *(please select):* ☐ Preterm Labor ☐ Hypertension ☐ Diabetes ☐ Meds During Pregnancy ☐ Drug/Alcohol use During Pregnancy ☐ Infection During Pregnancy ☐ Twin /triplet ☐ Other Problems During Pregnancy _____
2. **Length of pregnancy?** ☐ Term ☐ Overdue ☐ Premature # Weeks of gestation: _____
3. **Type of delivery**: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Vacuum Assisted ☐ Forceps Assisted
4. **Were there any delivery complications?** ☐ No ☐ Yes *(please select):* ☐ Prolonged labor ☐ Meconium ☐ Difficult Delivery ☐ Umbilical cord around neck ☐ Hemorrhage ☐ Fetal distress ☐ Other: _____
5. **Were there any problems after delivery?** ☐ No ☐ Yes *(please select):* ☐ Jaundice ☐ Breathing Problems ☐ Infection ☐ Bleed in Brain ☐ Eye problems ☐ Bowel Problems ☐ Ventilator needed (*how long* _____) ☐ Stayed in NICU *(how long* _____)

Developmental History

1. **When did patient reach the following developmental milestones compared to others his/her age?**
   (Please mark as **E** = early, **A** = average, or **L** = late) (please give timing and explain if late):
   - _____ Gross Motor Skills (rolling over, sitting, crawling, standing, walking)
   - _____ Fine Motor Skills (stacking blocks, thumb-finger grasp, drawing circle)
   - _____ Speech/Language (single words, sentences)
   - _____ Toilet Training

   Has there been any regression? _____

2. **Has the patient experience any of these problems?** ☐ No ☐ Yes *(please select):*

	No	Yes
Reverses of letters/#s		
Writes words backwards		
Delayed speech/language skills		
Poor speller		
Sounds out words to spell them		

	No	Yes
Trouble sounding out words		
Reads slowly or with stumbling		
Confuses vowels		
Trouble remembering words		
Getting letters/numbers out of order		

Sleep History

3. **Does the patient have a history of sleeping problems?** (since infant/toddler years) ☐ No ☐ Yes *(please select):*
   ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐ Sleep Walking ☐ Talking in Sleep ☐ Loud & frequent snoring
   ☐ Frequent Nightmares ☐ Frequent Night Terrors ☐ Vivid Dreams ☐ Takes naps during day ☐ Frequently falling asleep during day
   ☐ Difficult to get up in morning ☐ Often goes >24 hrs w/o sleep (*Does patient appear tired the next day?* ☐ Yes ☐ No)

SLEEP SCHEDULE *(may give range)*	**Weekdays**	**Weekends**
Usual Awakening time	am/pm	am/pm
Usual bedtime *(getting into bed)*	am/pm	am/pm
Usual Amount of time in bed before falling asleep	min.	min.

Family History

Biological (Birth) Parents' History

Is patient your biological child? YES NO If no, do you have knowledge of biological family history? YES NO

If no, please give relationship. ☐ *grandchild* ☐ *adopted* ☐ *foster child* ☐ *other* _____

Mother: Name:_____ Age ____ yrs Date of present marriage: ___/ ___ /___

Date(s) of prior marriage(s) & when dissolved: ___/___/___ *until* ___/___/___ ___/___/___ *until* ___/___/___

Highest grade completed in school _____ Current Occupation _____

Father: Name:_____ Age ____ yrs Date of present marriage: ___/ ___ /___

Date(s) of prior marriage(s) & when dissolved: ___/___/___ *until* ___/___/___ ___/___/___ *until* ___/___/___

Highest grade completed in school _____ Current Occupation _____

Biological siblings *Names / ages of sisters & brothers:* 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Chronic family Illnesses *(Please √ "None" for negative responses - we cannot assume "none" if left blank. Provide any needed explanations below)*

	None	Mother	Father	Brother(s)	Sister(s)	Other family members *(specify)*
ADHD						
Learning disabilities						
Autism or other developmental disorders						
Anxiety disorder						
Depression						
Bipolar disorder						
Seizure disorder						
Alcoholism						
Other substance abuse or addiction						
Hypertension						
Heart attack at less than 50 yrs old						
Abnormal heart rhythm (please specify)						
Other heart disease (please specify)						
Sudden Death at less than 50 yrs old						
Thyroid Disease						
Other chronic illnesses (please specify)						