



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:

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:



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 or 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

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 <i>(May or may not be covered under insurance)</i>	Testing/Assessment Codes
<ul style="list-style-type: none"> • QbTest • Clinicom • Behavior Rating Scales <i>(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.)</i> 	96120 & 96119 96103 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:



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

<input type="checkbox"/> I authorize Focus-MD to release information to:	OR	<input type="checkbox"/> I authorize Focus-MD to obtain information from:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone Number	_____ Fax Number	_____ 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)



**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:

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:

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 (*amenorrhea*)
 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 Affect / 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



College History Form

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

Birth Date: ___ / ___ / ___ Age: ___ years Gender: Male Female

Your Cell Phone: () ___ - _____ Preferred e-mail address: _____

Current school: _____ Academic level: FR SO JR SR Graduate (year # _____)

Where are you currently living? dorm apartment / condo house other _____

When at school with which of the following people do you presently live? (check all that apply):

roommate(s) # ___ parent(s) sibling(s) spouse children # ___ other(s) _____

Local Address: _____
street city state zipcode

School Performance: Current GPA _____ High school GPA _____ Major: _____

Where do you consider your hometown? _____ Which high school did you attend? _____

Permanent (Home) Address: _____
street city state zipcode

When at home with family with which of the following people do you presently live? (check all that apply) :

natural mother natural father stepmother stepfather grandmother grandfather
 adoptive mother adoptive father foster mother foster father split time between 2 homes
 children # ___ other(s) (please specify) _____

Are you currently employed? No Yes If yes, where do you work? _____

What is your position? _____ How many hours per week? _____

Please list all athletic, artistic & social activities in which you participate. _____

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 parents, teachers and other significant adults in patient's life.

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

In which settings do these concerns affect you?

Home School Work Social Sports Extra-curricular activities Others (please list) _____

Have you 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: _____

Patient's Medical History

1. Have you ever experienced any of the following?

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

2. Have you stayed overnight in the hospital? NO YES If yes, please give age and reason.

3. Have you ever had any surgery? NO YES If yes, please give age and procedure.

4. Have you 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.

Present Medical Condition

1. Are you being treated for any physical illnesses currently? No Yes

If yes, please list: _____

2. Are you taking any medications currently? No Yes

If yes, please list: _____

3. Have you had any legal problems in the past? NO YES

If yes, please describe.

4. In how many motor vehicle crashes have you been involved with as a driver? _____

In how many moving violations / traffic tickets have you received in the past? _____

5. How is your vision? Normal Vision impairment Wears eyeglasses or contacts Other _____

6. How is your hearing? Normal Some hearing impairment Uses hearing aid Other _____

7. Please indicate which of the following you have 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

1. Please use the form below to denote Yes (✓) or No (∅) to denote whether you had any of the listed academic or disciplinary problems during elementary (ES), middle (MS), or high school (HS). (Use back of page if you need to add or give details)

	ES	MS	HS
Not sustaining attention during classes			
Being redirected by teachers			
Talking excessively during classes			
Being disruptive in classes			
Fidgeting or getting out of seat excessively			
Acting or speaking without thinking			
Being known as the class clown			
Not turning in assignments			
Studying very little			
Not being challenged academically			
Having little motivation /Doing just enough to get by			
Teachers suggested ADHD testing			

2. Have you ever been diagnosed with ADHD in the past?

YES NO (skip to question #10)

- If yes, how old were you? _____ what grade? _____
- Who made the diagnosis?
 - Psychologist Pediatrician Family MD
 - Psychiatrist Other _____
- How was the diagnosis made? (check all that apply)
 - Interview by physician without testing
 - Checklists completed by parents Referral to psychologist
 - Checklists completed by teachers Testing with Computer
 - Checklist completed by you Psychological testing
 - IQ and achievement tests
 - Other _____
- Did you ever see a psychologist for psychological and/or educational testing? YES NO

3. Please list the medications you have received in the past for ADHD

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

4. Have you ever been diagnosed with any other emotional / behavioral health conditions (like depression, anxiety, or bipolar disorder)?

YES NO (skip to next page)

- If yes, which conditions?
 - Depression Bipolar disorder Anxiety disorder Social anxiety Panic attacks Obsessive-compulsive disorder Unsure
 - Other _____

5. Which other emotional / behavioral health medications (like antidepressants or mood stabilizers) have you taken?

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

Family History

Biological (Birth) Parents' History

Adopted

Birth parents unknown

Mother: Name: _____ Age _____

Father: Name: _____ Age _____

Current residence: _____

Current residence: _____

City: _____ State: _____

City: _____ State: _____

Highest grade completed in school _____ Occupation _____

Highest school grade completed _____ Occupation _____

Date of present marriage: ___/___/___

Date of present marriage: ___/___/___

Date(s) of prior marriage(s) & when dissolved:

Date(s) of prior marriage(s) & when dissolved:

___/___/___ until ___/___/___

___/___/___ until ___/___/___

(Please circle applicable descriptors) married / engaged / single / divorced / separated / never married to other parent / committed relationship / lives with significant other / other _____

(Please circle applicable descriptors) married / engaged / single / divorced / separated / never married to other parent / committed relationship / lives with significant other / other _____

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

3. _____ 4. _____ 5. _____

Chronic family illnesses *(Please V "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)						