Patient Name: _____ Date of Birth: ___/___/_____

New Patient Age 13-17 (Middle and High School Patients coming in with parents/guardians)

Thank you for taking the time to complete this packet. Your input is important and having this information before your appointment helps us use the time during your visit more efficiently to better address your concerns.

- Complete the information completely giving as much detail as possible.
- It is important to be honest. It is important for us to know what medications you take and other conditions you have so we can make the best decisions about your condition and care.
- Don't worry about answering the questions incorrectly or be concerned that you might 'label' yourself. There are no right or wrong answers.
- If you are unsure of an answer, provide an answer which best describes you a good deal of the time in that situation.
- It may seem like we are asking for a lot of information about you, however, it is just our effort to be as comprehensive and accurate as possible with our diagnosis.

Name of person completing this form: _____

Relationship to patient, if not patient completing form: _____

To start, tell us your specific concerns about symptoms and problems you are having that you want to make sure we cover during your appointment? ***(Preferably, we'd like the patient to complete this section, although, if a parent or caregiver wants to add a statement, we welcome that as well).**

REVIEW OF SYSTEMS:

Constitutional

☐ Yes ☐ No Problems Falling Asleep
☐ Yes ☐ No Trouble Staying Asleep
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Daytime Sleepiness
☐ Yes ☐ No Decreased Appetite at lunch
☐ Yes ☐ No Decreased Appetite in general
☐ Yes ☐ No Weight Gain
☐ Yes ☐ No Weight Loss

Eyes

☐ Yes ☐ No Frequent Blinking/Squinting
☐ Yes ☐ No Vision Problems (**other than corrective lenses**)
☐ Yes ☐ No Itching/Rubbing Eyes

Ears/Nose/Throat

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

Respiratory

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

Heart/Vascular

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

Gastrointestinal

☐ Yes ☐ No Frequent Abdominal Pain
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Stool Leakage/Accidents
☐ Yes ☐ No Constipation
☐ Yes ☐ No GERD/Reflux/Frequent Heartburn
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Blood in Stool

Genito/Urinary

☐ Yes ☐ No Bed Wetting
☐ Yes ☐ No Urine Accident/Incontinence
☐ Yes ☐ No Frequent Urinating
☐ Yes ☐ No Irregular, Heavy Period
☐ Yes ☐ No Significant Menstrual Pain

Skin/Hair/Nails

☐ Yes ☐ No Sores or Rashes
☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Itchy skin
☐ Yes ☐ No Acne
☐ Yes ☐ No Twirls or Pull Hair
☐ Yes ☐ No Picks at Skin, Nails

Neurological

☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Verbal Tics – Sniffing, Throat Clearing, Vocalizing
☐ Yes ☐ No Motor Tics – Blinking, Jerking
☐ Yes ☐ No Tremor
☐ Yes ☐ No Blank Staring Spells
☐ Yes ☐ No Seizures
☐ Yes ☐ No Weakness

Musculoskeletal

☐ Yes ☐ No Limp or Gait Disturbance
☐ Yes ☐ No Clumsy
☐ Yes ☐ No Joint Pain

Endocrine

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Problems with Growth/Short Stature
☐ Yes ☐ No Frequent Urination/Drinks Excessive Fluids
☐ Yes ☐ No Thyroid Problems

Heme/Lymph

☐ Yes ☐ No Anemia
☐ Yes ☐ No Easily Bruised

Allergic/Immunologic

☐ Yes ☐ No Eczema
☐ Yes ☐ No Asthma

Psychiatric

☐ Yes ☐ No Anxious, Worries
☐ Yes ☐ No Sensory Issues- i.e. Hates Tags, Loud Noises, Problems with Food Textures
☐ Yes ☐ No Obsessive Compulsive Behaviors
☐ Yes ☐ No Rigid, Inflexible
☐ Yes ☐ No Depressed, Sad
☐ Yes ☐ No Irritable, Touchy
☐ Yes ☐ No Mood Issues Related to Menstruation
☐ Yes ☐ No Flat Effect/Zombie-like
☐ Yes ☐ No Frequent Anger
☐ Yes ☐ No Aggression
☐ Yes ☐ No Paranoid, hears/sees things others don't
☐ Yes ☐ No Special Abilities
☐ Yes ☐ No Apathetic/Lazy
☐ Yes ☐ No Low Self Esteem
☐ Yes ☐ No Racing Thoughts
☐ Yes ☐ No Thoughts of Self Harm, Suicide
☐ Yes ☐ No Attempts at Self Harm, Suicide
☐ Yes ☐ No Cutting Behavior
☐ Yes ☐ No Hypersexual Behavior
☐ Yes ☐ No Overly Confident or Grandiose
☐ Yes ☐ No Not Sleeping for over 24 Hours

ALLERGIES (list all food, drug, environmental *and* reaction if known):

_____

_____

CURRENT MEDICATIONS (*OTHER than* ADHD meds-include supplements and meds for all other medical issues):

_____ _____

_____ _____

_____ _____

CURRENT *ADHD* MEDICATIONS*:*

Medication Name_____Dose_____Effectiveness_____Side effects_____

_____

_____

_____

PAST ADHD MEDICATIONS:

Medication Name_____Dose_____Effectiveness_____Side effects_____

_____

_____

_____

Behavioral/Mental Health History:

Have you ever been previously diagnosed with ADHD? ☐ Yes ☐ No

Have you been diagnosed with any other learning problems? ☐ Yes ☐ No
Explain: _____

At what age (**or approximately when**) did ADHD symptoms become a problem for you? _____

In what areas of your life do ADHD symptoms bother you?

☐ Home
☐ Work
☐ School behavior
☐ School performance
☐ Homework
☐ Driving
☐ Family relationship (parents, siblings, sig others)
☐ Friend relationships
☐ Other: _____

Have you had any of the following problems at school?

- ☐ Attention Problems
- ☐ Difficulty Reading
- ☐ Discipline Problems
- ☐ Poor School Performance
- ☐ Difficulty w/Math
- ☐ Work Hard w/Inferior Results
- ☐ Under Performance
- ☐ Turned in Work Late

Do you have any accommodations at school? (ex. IEP, 504 plan, extra time for exams) ☐ Yes ☐ No
If yes, explain: _____

Have you ever participated in any of the following treatments or therapies? ☐ Yes ☐ No

□	ADHD Coaching/counseling	□	Behavioral Modification	□	Occupational Therapy
□	Speech Therapy	□	Reading Intervention	□	Special Education

Have you ever been diagnosed/treated for any of the following?

Learning Disorder (specify: _____)

- ☐ Anxiety
- ☐ Depression
- ☐ Panic Disorder/panic attacks
- ☐ Bipolar Disorder
- ☐ OCD
- ☐ Tics/Tourette Syndrome
- ☐ Autism Spectrum
- ☐ Substance Abuse
- ☐ Other

***FAMILY HISTORY*:**

- Please indicate with a √ if any of your immediate family members have experienced any of the following conditions.

	Mother	Father	Sibling(s)	Grandparent	Other family: list
ADHD					
Learning Disorder					
Anxiety					
Panic Disorder					
OCD					
Mood Disorder					
Bipolar Disorder					
Depression					
Schizophrenia					
Tics/Tourette's					
Headache/Migraines					
Autism/Asperger's					
Seizure Disorder					
Addiction/Substance Abuse					
Heart Disease Under Age of 40					
High Blood Pressure					
Stroke					
Diabetes					
Cancer					
Asthma					

MEDICAL HISTORY:

Newborn History:

- Were there any pregnancy complications? □ Yes □ No
  □ Preterm Labor □ Meds During Pregnancy □ Drug/Alcohol use During Pregnancy
  □ Other Exposure During Pregnancy □ Infection During Pregnancy □ Hypertension □ Diabetes
- Length of pregnancy? # Weeks: _____
- Type of delivery: □ C-Section □ Vaginal □ Vacuum Assisted □ Forceps Assisted □ Meconium
- Were there any delivery complications? □ Yes □ No
  □ Difficult Delivery □ Nuchal Cord □ Hemorrhage
- Were there any problems after delivery? □ Yes □ No
  □ Jaundice □ Breathing Problems □ Bleeding in Brain □ Bowel Problems □ Sepsis/Infection

Patient Name: _____

Developmental History:

Please mark when the patient achieved the following milestones (E = early, A = average, or L = late) as compared to others (explain if late):

- _____ Speech/Language (single words, sentences)
- _____Fine Motor Skills (stacking blocks, thumb-finger grasp, drawing circle)
- _____Gross Motor Skills (rolling over, standing, walking)
- _____Toilet Training
- Did you ever have any regression in these areas? _____

Sleep History*:*

- Do you have a history of sleeping problems? (since infant/toddler years) □ Yes □ No
  □ Trouble Falling Asleep □ Trouble Staying Asleep □ Sleep Walking □ Talking in Sleep
  □ Frequent Nightmares □ Frequent Night Terrors □ Vivid Dreams
- Have you gone longer than 24 hours without sleep? □ Yes □ No
  If yes, were you tired the next day? □ Yes □ No How often has this occurred? _____
  What is the maximum number of days you have gone without sleep? _____
- Do you sleep after school/work? □ No □ Yes, Daily □ Yes, Occasionally
  How long do you sleep? _____
- Do you feel tired during the day? □ Yes □ No Do you fall asleep during the day? □ Yes □ No

General Medical History:

- Have you ever been hospitalized? □ Yes □ No
  If yes, please explain: _____
- Have you ever had a concussion or head injury? □ Yes □ No If yes, date: _____
- How is your vision? □ Normal □ Some vision impairment □ Wear corrective lenses/contacts
- How is your hearing? □ Normal □ Some hearing loss □ Uses hearing aid

Please check if you have ever experienced any of the following symptoms or conditions: □ None

□	Heart Murmur	□	Cardiac Abnormality	□	Asthma
□	Enuresis or bedwetting	□	Seizures	□	Constipation/Diarrhea
□	Diabetes	□	Thyroid Problems	□	Frequent Ear Infections
□	Reflux	□	Headaches/Migraines	□	Other:
If yes, please explain:					

Patient Name: _____

SURGICAL HISTORY:

- Tubes ☐ Yes ☐ No # Sets _____ 1st set at what age? _____
- Adenoidectomy ☐ Yes ☐ No
- Tonsillectomy ☐ Yes ☐ No
- Other surgery: _____

SOCIAL HISTORY:

- Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married
- With whom do you live? ☐ Parents ☐ Mom ☐ Dad ☐ Mom/Step-dad ☐ Dad/Step-mom ☐ Grandparent ☐ Other relative ☐ Non-relative
- Do you have a consistent nighttime routine? ☐ Yes ☐ No
- When do you go to sleep/wake up: ____PM ____AM
- TV in bedroom: ☐ Yes ☐ No
- Do you have any dietary restrictions? ☐ Yes ☐ No ☐ Yes, Explain _____
  ☐ Regular diet ☐ Vegetarian ☐ Other _____
- How would you rate your physical activity level?
  ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/couch potato
- Where do you attend school? _____Grade: _____
- How is your academic performance? ☐ Good ☐ Fair ☐ Poor ☐ Failing/Danger of failing
  ☐ Problems with reading ☐ Problems with writing ☐ Problems with math
  - ☐ Not a problem ☐ Somewhat of a problem ☐ Moderate Problem ☐ Significant Problem
- How is your school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns ☐ Other
  - ☐ No problem ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem
- Do you receive any school based accommodations? ☐ Yes ☐ No

☐ Resource classroom	☐ Individual testing
☐ IEP	☐ Reduced work volume
☐ 504 Plan accommodation	☐ Response to intervention
☐ Extended time on testing	☐ Informal accommodations
☐ Testing in a quiet environment	☐ Other: _____

- How much time do spend per day doing the following? (____hr/day)

☐ Homework_____	☐ TV _____
☐ Job_____	☐ Video games _____
☐ Extracurricular activities_____	☐ Computers/social media _____
☐ Sports _____	☐ Other _____
☐ Unstructured play/downtime _____	

Patient Name: _____

- Describe your special interests/hobbies (ex. Sports, drama, music, martial arts, fine arts, etc.)

  _____

- Describe your after-school routine:
  - ☐ Tutoring/educational intervention
  - ☐ After school job
  - ☐ Volunteer
  - ☐ Complete homework after school
  - ☐ Homework completed in evening
  - ☐ School sponsored club/extracurricular
  - ☐ School sports team
  - ☐ Rides bus
  - ☐ Car rider/I drive to school

- Describe your behavior at home?
  - ☐ Good behavior
  - ☐ Problems with time management
  - ☐ Problems with task completion
  - ☐ Meltdowns
  - ☐ Homework problems
  - ☐ Oppositional behavior
  - ☐ Disrespectful behavior
    - ☐ Somewhat of a Problem ☐ Moderate Problem ☐ Significant problem

- Do you have a job? ☐ No ☐ Yes, Part Time ☐ Yes, Full Time Type of work? _____
- How is your relationship with your family?
  - ☐ No unusual stress
  - ☐ Conflict with parent(s)
  - ☐ Conflict with non-custodial parent
  - ☐ Conflict with siblings
  - ☐ Step-parent/child conflict
  - ☐ Conflict with other family members
    - ☐ Somewhat of a Problem ☐ Moderate Problem ☐ Significant problem
- How are your relationships with your peers?
  - ☐ I have several friends
  - ☐ I don't really have close friends
  - ☐ Significant conflict
  - ☐ Limited friendships
  - ☐ Some conflicts
  - ☐ Problems making/keeping friends
    - ☐ Somewhat of a Problem ☐ Moderate Problem ☐ Significant problem
- Have you had any issues with bullying?
  - ☐ No problems
  - ☐ I have been teased/picked on
  - ☐ I have bullied others
  - ☐ Bullying is ongoing
  - ☐ Bullying is being addressed
    - ☐ Somewhat of a Problem ☐ Moderate Problem ☐ Significant problem
- Have there been any major stressors in the past year? ☐ Yes ☐ No
  - ☐ Family conflict
  - ☐ Peer relationships
  - ☐ School performance
  - ☐ Sibling relationships
  - ☐ Financial stressors
  - ☐ Substance abuse in home
  - ☐ Absent parent
  - ☐ Serious illness in the family
  - ☐ Death in the family
  - ☐ Natural disaster
  - ☐ Loss of housing
  - ☐ Other: _____

Patient Name: _____

- How many caffeinated beverages do you consume a day?

  ☐ None ☐ <1 per day ☐ 1-3 per day ☐ 3+ per day

- Do you use alcohol? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Abuse ☐ Concern for addiction

- Do you use chewing tobacco/smoke? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Do you use marijuana? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Have you used other drugs? ☐ Yes ☐ No What Drug(s): _____

- What is your driving history?

  ☐ No moving traffic violations
  ☐ 2 or less moving traffic violations
  ☐ 3 or more moving traffic violations
  ☐ License suspended/revoked
  ☐ No accidents
  ☐ 2 or less accidents
  ☐ 3 or more accidents

- Do you have any legal issues? ☐ Yes ☐ No

  ☐ Minor w/possession of alcohol
  ☐ Vandalism
  ☐ Stealing/shoplifting
  ☐ Other charges
  ☐ On probation
  ☐ Possession of drugs
  ☐ Truancy
  ☐ Fighting/assault
  ☐ Prior incarceration
  ☐ Off probation

Use back of page, if needed, to discuss any other pertinent medical, mental, social, family history