Patient Name: _____ Date of Birth: _____

New Patient-Ages 4-12

Thank you completing this packet.

This patient is being assessed for Attention Deficit Hyperactivity Disorder (ADHD).

Your input is very important. Complete the information as completely as possible giving as much detail as you are able. Having this information before your appointment helps us use the time at your visit to better address your concerns.

While this may seem like a lot of information to give, it is our effort to be as comprehensive and accurate as possible with our diagnosis.

_____

Name of person completing this form: _____
Relationship to patient: _____

What are your main concerns regarding the patient? (use space below)
(i.e. inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behaviors, etc.):

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS: (Current problems)

Constitutional
- ☐ Yes ☐ No Problems Falling
- ☐ Yes ☐ No Problems Staying Asleep
- ☐ 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/Heartburn
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Blood in Stool

Genito/Urinary
- ☐ Yes ☐ No Bed Wetting
- ☐ Yes ☐ No Urine Accident/Incontinence
- ☐ Yes ☐ No Irregular, Heavy Period
- ☐ Yes ☐ No Significant Menstrual Pain

Skin/Hair/Nails
- ☐ Yes ☐ No Sores or Rashes
- ☐ Yes ☐ No Hair Loss
- ☐ Yes ☐ No Acne
- ☐ Yes ☐ No Twirls or Pull Hair
- ☐ Yes ☐ No Picks/bites 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 Asthma
- ☐ Yes ☐ No Eczema

Psychiatric
- ☐ Yes ☐ No Anxious, Worries
- ☐ Yes ☐ No Sensory Issues- 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 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_____

_____

_____

_____

ADHD History

- At what age did you first notice symptoms of ADHD? _____
- Has the patient ever been formally diagnosed with ADHD? ☐ Yes ☐ No
  If yes, when was the diagnosis made and by whom? _____
  - Do you have documentation of the diagnosis? ☐ Yes ☐ No
  - Is the patient currently under a provider's care for ADHD? ☐ Yes ☐ No

  Reasons for changing ADHD provider? _____
- Has the patient ever received IQ/Academic/psychoeducational testing? ☐ Yes ☐ No
  - **Diagnosis?** _____
- Has the patient 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

In what areas do you see inattention, hyperactivity, impulsivity affecting the patient?

☐ School behavior ☐ Home work ☐ Sports

☐ Academic performance/learning ☐ Family relationships ☐ Other _____

☐ Peer relationships ☐ Extracurricular activities

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	Aunt/Uncle
ADHD					
Learning Disorder					
Anxiety					
Panic Disorder					
OCD					
Bipolar Disorder					
Depression					
Schizophrenia					
Tics/Tourette's					
Migraine Headaches					
Autism Spectrum Disorder					
Seizure Disorder					
Addiction/Substance Abuse					
Heart Disease Under Age of 40					
High Blood Pressure					
Stroke					
Diabetes					
Cancer					
Asthma					
Other Significant Condition					

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

  ☐ Other:_____

Developmental History:

Mark when the patient achieved the following milestones (E = early, A = average, or L = late) 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

Has there been any regression? _____

Sleep History:

- Does the patient 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
- Has the patient gone longer than 24 hours without sleep? ☐ Yes ☐ No
  If yes, did the patient seem tired the next day? ☐ Yes ☐ No
  How often has this occurred? _____
  What is the maximum number of days the patient has gone without sleep? _____
- Does the patient sleep after school? ☐ No ☐ Yes, Daily ☐ Yes, Occasionally
  How long does he/she sleep? _____
- Does the patient seem tired during the day? ☐ Yes ☐ No
- Does the patient nap during the day? ☐ Yes ☐ No

Does the patient experience any of the following conditions or symptoms?

- Depression (sad, irritable, hopeless, tearful, lack of interest, social withdrawal) ☐ Yes ☐ No
- Anxiety (worry, fearful, obsessive thoughts, frequent headaches/stomach aches) ☐ Yes ☐ No
- Behavioral problems (defiance, argumentative, refusals, anger, aggression, school suspensions or detentions) ☐ Yes ☐ No
- Verbal tics (throat clearing, repeating words) ☐ Yes ☐ No
- Motor tics (blinking, face muscle twitching) ☐ Yes ☐ No

General Medical History:

- Has the patient ever been hospitalized? ☐ Yes ☐ No

  If yes, please explain: _____
- Has the patient ever had a concussion or head injury? ☐ Yes ☐ No If yes, date: _____
- How is the patient's vision? ☐ Normal ☐ Vision impairment ☐ Wear corrective lenses or contacts
- How is the patients's hearing? ☐ Normal ☐ Some hearing impairment ☐ Uses hearing aid

Please check if the patient has ever experienced any of the following symptoms or conditions: ☐ None

☐	Heart Murmur	☐	Cardiac Abnormality	☐	Asthma
☐	Enuresis (daytime accidents)	☐	Bedwetting	☐	Encopresis (soiling w/stool)
☐	Constipation/Diarrhea	☐	Thyroid Problems	☐	Frequent Ear Infections
☐	Seizures	☐	Reflux	☐	Frequent Headaches
☐	Diabetes	Other:			

SURGICAL HISTORY:

- Ear Tubes: ☐ Yes ☐ No # Sets _____ 1st set at what age? _____
  Other Surgeries: _____
  _____

SOCIAL HISTORY:

- Is the patient your biological child? ☐ Yes ☐ No
- If adopted, when was the patient adopted (what age)? _____
  - How much do you know about the patient's biological family?

    _____
- Has the patient ever been the victim of abuse or neglect? ☐ Yes ☐ No
- Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married
- The patient lives with: ☐ Parents ☐ Mom ☐ Dad ☐ Mom/Step-dad ☐ Dad/Step-mom ☐ Grandparent

☐ Other relative ☐ Non-relative ☐ Other _____

If patient does not live with both parents, how often does the patient see the non-custodial parent?

☐ Frequently/equally ☐ At least weekly ☐ Rarely ☐ No relationship

☐ Every other week ☐ Monthly ☐ Less than monthly

- Does the patient have a consistent nighttime routine? ☐ Yes ☐ No

  ☐ Has a TV in the bedroom ☐ Watches TV/uses electronics before bedtime

  Usual bed time: _____ Usual wake time: _____
- Does the patient have any dietary restrictions? ☐ Yes, Explain. _____

  ☐ Regular diet ☐ Vegetarian ☐ Other _____
- How would you rate the patient's physical activity level?

  ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/couch potato
- How many caffeinated beverages does the patient drink each day?

  ☐ None ☐ <1 ☐ 1-3 per day ☐ 3+ per day
- Where does the patient attend school? _____ Grade: _____
- ☐ Public School ☐ Private School ☐ Home School ☐ Religious Affiliated School ☐ Charter School ☐ Other
- How is the patient's academic performance? ☐ Good ☐ Fair ☐ Poor ☐ Failing/Danger of failing

  ☐ Problems with reading ☐ Problems with writing ☐ Problems with math

  ☐ No Problem ☐ Somewhat of a problem ☐ Moderate Problem ☐ Significant Problem
- How is the patient's school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns ☐ Other

  ☐ No problem ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem
- Does the patient receive any school based accommodations? ☐ Yes ☐ No ☐ Needed, but reluctant to use

  ☐ 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: _____

- Describe the patient's hobbies/special interests (ex. Sports, music, art, fishing, etc.):

  _____

  _____

  _____

- How much time does the patient spend each day with the following:

  ☐ Video Games: _____ hrs/day

  ☐ TV: _____

  ☐ Computer/social media: _____

  ☐ Unstructured Playtime: _____

  ☐ Homework: _____

- Describe the patient's after school routine:
  - ☐ Tutoring/Educational Intervention ☐ After school care ☐ Rides Bus
  - ☐ Unstructured ☐ Car Rider
  - ☐ Homework is done after school ☐ Homework is delayed until evening

- How is the patient's behavior at home (check all that apply)?
  - ☐ Good behavior ☐ Homework problems ☐ Meltdowns
  - ☐ Problems with time management ☐ Oppositional behavior ☐ Problems with task completion
  - ☐ Disrespectful behavior
  - ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the patient's relationships with family members?
  - ☐ No unusual stress ☐ More than usual conflict with siblings
  - ☐ Parent/child conflict ☐ Step-parent/child conflict
  - ☐ Conflict with non-custodial parent ☐ Conflict with custodial parent/guardian
  - ☐ Conflict with other family members
  - ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the patient's relationships with peers?
  - ☐ Healthy, identifies friends ☐ Limited friendships
  - ☐ Doesn't identify friends ☐ Some conflicts
  - ☐ Significant conflict ☐ Problems making/keeping friends
  - ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any bullying issues?
  - ☐ No problems ☐ Patient is teased/picked on
  - ☐ Patient bullies others ☐ Bullying is ongoing
  - ☐ Bullying is being addressed
  - ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any major stressors for the patient during the past year?
  - ☐ Family conflict ☐ Absent parent
  - ☐ Peer relationships ☐ Serious illness in the family
  - ☐ School performance ☐ Death in the family
  - ☐ Sibling relationships ☐ Natural disaster
  - ☐ Financial stressors ☐ Loss of housing
  - ☐ Substance abuse in home ☐ Other: _____