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

New Patient 18+

Thank you for completing 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.
- Be honest. We do not disclose this information to anyone without your consent.
- 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 important for us to have this information so we can be as comprehensive and accurate as possible with our diagnosis.

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?

REVIEW OF SYSTEMS:

Constitutional
☐ Yes ☐ No Problems Falling Asleep
☐ Yes ☐ No Problems Staying Asleep
☐ Yes ☐ No Decreased Appetite at lunch
☐ Yes ☐ No Decreased Appetite all day
☐ Yes ☐ No Daytime sleepiness/fatigue
☐ Yes ☐ No Weight Gain
☐ Yes ☐ No Weight Loss

Eyes
☐ Yes ☐ No Frequent Blinking/Squinting
☐ Yes ☐ No Vision Problems-**other than glasses/contacts**
☐ 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 Twirls or Pull Hair
☐ Yes ☐ No Skin picking
☐ Yes ☐ No Nail biting or picking cuticles

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 Depressed, Sad
☐ Yes ☐ No Low Self Esteem
☐ Yes ☐ No Low frustration tolerance
☐ Yes ☐ No Sensory Issues- Hates Tags, Loud Noises, Problems with Food Textures
☐ Yes ☐ No Obsessive Compulsive Behaviors
☐ Yes ☐ No Rigid, Inflexible
☐ 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 Apathetic/Lazy
☐ 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_____

_____

_____

_____

ADHD History:

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

If yes, When/What age? _____

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 (bills, organization, run of house)
☐ Work (performance, multiple jobs, enjoyment)
☐ School behavior
☐ School performance
☐ Homework
☐ Driving
☐ Family relationship (parents, siblings, sig others)
☐ Peer relationships (work, social)
☐ Other: _____

Do/did you have any of the following problems while in school?

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

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

Did/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

In the past two weeks, how often have you been bothered by the following problems?
0 – Not at all 1 – Several days 2 – More than half the days 3 – Nearly every day

Symptom	GAD-7 Screen	Rating: 0 to 3 (see above)
Feeling nervous, anxious, or on edge		
Not being able to stop or control worrying		
Worrying too much about different things		
Trouble relaxing		
Being so restless that it is hard to sit still		
Becoming easily annoyed or irritable		
Feeling afraid as if something awful might happen		
TOTAL SCORE:		

If you checked off any above problems, **how difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely

Symptoms	PHQ-9 Screen	Rating 0 to 3 (see above)
Little interest or pleasure in doing things		
Feeling down, depressed, or hopeless		
Trouble falling or staying asleep, or sleeping too much		
Poor appetite or overeating		
Feeling bad about yourself — or that you are a failure or have let yourself or your family down		
Trouble concentrating on things, such as reading the newspaper or watching television		
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual		
Thoughts that you would be better off dead or of hurting yourself in some way		
TOTAL SCORE:		

If you checked off any above problems, **how difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely

Have you been diagnosed with any of the following conditions? ☐ Yes ☐ No

☐ Learning Disorder (specify: _____)
☐ Anxiety
☐ Depression
☐ Panic Disorder/panic attacks
☐ Bipolar Disorder
☐ OCD
☐ Tics/Tourette Syndrome
☐ Autism Spectrum
☐ Substance Abuse
☐ Other mental health issue: _____

Treatment/therapies for any of the above:

FAMILY HISTORY:

Please indicate with a √ if any of your immediate family members have experienced any of the following conditions.
Initial if none: _____

	Mother	Father	Sibling	Children	Grandparent	other: list
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Mood Disorder (ex. Bipolar)						
Schizophrenia						
Depression						
Tics/Tourette's						
Autism/Asperger's						
Frequent Headaches/Migraines						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age of 40						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						
Other significant conditions:						

MEDICAL HISTORY:

Sleep History:

Do you have a history of sleep problems? □ Yes □ No

□ Trouble falling asleep □ Trouble staying asleep □ Vivid dreams □ Sleep Apnea
□ Talking in sleep □ Frequent nightmares □ Walking in sleep

Have you gone more than 24 hours without sleep? □ Yes □ No Was it Work or School Related? □ 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 feel tired during the day? □ Yes □ No Do you nap during the day? □ Yes □ No

Check if you have any of the following conditions:

□	Hypertension	□	High Cholesterol	□	Heart Attack
□	Heart Murmur	□	Arrhythmia	□	Heart Abnormality
□	Stroke	□	Fainting	□	Thyroid Disease
□	Diabetes	□	Cancer	□	Asthma
□	COPD	□	Head Injury Date: _____	□	Seizure Disorder
□	Migraine	□	Headaches	□	Reflux
□	Arthritis	□	Restless Legs Syndrome	□	Sleep Disordered Breathing/apnea
□	Restless Leg Syndrome	□	**Other:**		

□	Normal Vision	□	Vision Impaired	□	Contacts	□	Glasses
□	Normal Hearing	□	Hearing Impaired	□	Hearing Aids		

SURGICAL HISTORY: (Procedure and Date ex: appendectomy 2000)

_____ _____

_____ _____

SOCIAL HISTORY: (answer as applies to you)

How do you classify yourself? □ Married □ Single □ Divorced □ Separated □ Widowed □ Partnered
□ Other: _____

With whom do you live? □ Myself □ Spouse/Significant Other □ Spouse/Partner & Children □ Sibling
□ Relatives □ Roommate □ Friend □ Other: _____

Do you have children? If yes, how many? _____ How many live with you? _____

What is your highest level of education? □ Did not complete HS □ HS graduate □ GED or equivalent
□ Trade/Technical school □ Some college □ Still working on degree □ Associate Degree □ Bachelor's Degree
□ Master's degree □ Doctorate □ Working on degree (specify: _____)

Are you currently in school? □ Yes □ No Where do you attend school? _____

What year are you in your studies? _____ Field of Study: _____

What type of Work do you do? _____

How long have you been at your current job? _____

What is your employment status? □ FT □ PT □ Temp □ Seasonal □ Retired □ Unemployed □ Disabled

Do you exercise regularly? □ Yes □ No What do you like to do for exercise? _____

How would you classify your diet? (Ex. Regular, vegan, low carb) _____

What is your general stress level? □ Low □ Medium □ High □ Average □ Worsening □ Improving

In the past year, have you had any recent life stressors?

□ None	□ Marriage	□ New Relationship
□ Divorce	□ Significant health diagnosis	□ Retirement
□ Job instability	□ Job loss	□ Relocation
□ Loss of loved one	□ Loss of relationship	□ School/academics

□ Other: _____

What is your driving history? □ No moving traffic violations □ No accidents
□ 2 or less moving traffic violations □ 2 or less accidents □ License suspended/revoked
□ 3 or more moving traffic violations □ 3 or more accidents

How many caffeinated beverages do you consume a day? □ None □ <1 per day □ 1-3 per day □ 3+ per day
(What is your caffeine drink of choice? _____)

Do you use alcohol? □ Yes □ No Do you feel you have a problem with alcohol? □ Yes □ No
□ Several drinks daily □ One a day □ A few days a week □ Weekends/socially □ Binge drinking

Do you use tobacco products? □ Yes □ No □ cigarettes □ e-cigs □ chewing tobacco □ other
□ daily use □ other, describe: _____

Do you use street/illicit drugs? □ Yes □ No Do you feel you have a problem with illicit drugs? □ Yes □ No
□ Drug(s) used: (Ex. pot, cocaine, heroin, etc.) _____
□ Infrequent □ Frequent □ Regularly

Have you ever had an issue with misuse/abuse of prescription drugs? Ex: stimulants, narcotics, benzodiazepines
□ Yes □ No

Have you ever needed any sort of treatment for drug abuse/misuse? □ Yes □ No
□ Inpatient Care □ Outpatient Care □ Suboxone or other medicine management

_____