



Welcome to Focus-MD!

We give our full attention to ADHD and the problems that go along with it. Our solution looks at the whole patient and we want to begin to get to know you before you arrive for your first visit!

Please fill out the forms that follow completely and feel free to give as much information as needed. Having this information before your appointment helps us use the time at your visit to better address your concerns.

We combine the information in this packet and the information you provide during your appointment with our FDA cleared state-of-the-art objective testing to help arrive at a more accurate diagnosis.

Whether you are ultimately diagnosed with ADHD and/or some related condition or not we provide support and recommendations to help you address your concerns. Again, we care about the whole person not just the diagnosis.

If ADHD treatment is needed we will explain our recommendations and provide the same careful attention to treatment that we do when making a diagnosis. When medication is used we work with you to find the right solution. No one wants to change their personality to a zombie state and at Focus-MD we don't want that either! Response to medication varies significantly from one person to another and our solution helps find the optimal dose of the right medication for you.

Medication is usually an important part of treatment and often the first step. Focus-MD is about more than medicine though. We are growing our resources to help with ADHD challenges that may not get better with medication alone.

Finally, Focus-MD provides careful follow-up to ensure you are making progress in reaching your goals with minimal medication side effects. We will discuss a follow-up plan with you during your first visit.

Thank you for choosing Focus-MD. We are committed to taking you and your family from frustration to focus.

Please return this paperwork in person, by
US Mail, or by confidential fax to:

Focus-MD Hendersonville
105 Bluegrass Commons Blvd, Suite B
Hendersonville, TN 37075

Phone: 615-686-2346
Fax: 877-369-7549

Help Us Get to Know You

Please have the patient/child complete this questionnaire.

What do you do well?

What do you enjoy doing most?

Do you find it hard to sit still or do you feel restless during class sessions or in small groups?

Does caffeine affect your sleep?

Do you feel that you finish other people's statements, interrupt, or are impulsive when having to wait to offer comments or ask questions in a classroom/group environment?

Do you find it hard to stay focused when listening to lectures in a classroom setting or meeting?

Do you re-read paragraphs or pages because you didn't get them the first time?

Do your friends and family think you talk too much?

Are you always looking for your phone or keys, or frequently misplace things?

Is procrastination a problem for you?

Do you get frustrated and overwhelmed with schoolwork and job responsibilities?

Are you frequently late or have time management problems?

Are you a worrier?

Do you feel unhappy a lot?

Do you have trouble making or keeping friends?

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

REVIEW OF SYSTEMS:
Constitutional

- Yes No Decreased Appetite
- Yes No Decreased Appetite at Lunch
- Yes No Excessively Sleepy
- Yes No Fatigue
- Yes No Problems Falling/Staying Asleep
- Yes No Tired
- Yes No Weight Gain
- Yes No Weight Loss

Eyes

- Yes No Frequent Blinking/Squinting
- Yes No Itching/Rubbing Eyes
- Yes No Vision Problems

Ears/Nose/Throat

- 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
- Yes No Trouble Breathing

Heart/Vascular

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

Gastrointestinal

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

Musculoskeletal

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

Psychiatric

- Yes No Aggression
- Yes No Anxious, Worries
- Yes No Apathetic/Lazy
- Yes No Attempts at Self Harm, Suicide
- Yes No Cutting Behavior
- Yes No Depressed, Sad
- Yes No Flat Effect/Zombie-like

Psychiatric

- Yes No Frequent Anger
- Yes No Hypersexual Behavior
- Yes No Irritable, Touchy
- Yes No Low Self Esteem
- Yes No Mood Issues Related to Menstruation
- Yes No Not Sleeping for over 24 Hours
- Yes No Obsessive Compulsive Behaviors
- Yes No Overly Confident or Grandiose
- Yes No Paranoid, hears/sees things others don't
- Yes No Racing Thoughts
- Yes No Rigid, Inflexible
- Yes No Sensory Issues- Hates Tags, Loud Noises, Problems with Food Textures
- Yes No Special Abilities
- Yes No Thoughts of Self Harm, Suicide

Skin/Hair/Nails

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

Neurological

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

Endocrine

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

Genito/Urinary

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

ALLERGIES:

 Do you have any drug allergies? Yes No

If so, please name and describe the reaction: _____

 The reaction is Mild Moderate Severe

 Do you have any food allergies? Yes No

If so, please name and describe the reaction: _____

 The reaction is Mild Moderate Severe

CURRENT ADHD MEDICATIONS: None

Medication Name	Dosage	Frequency	Duration
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
<i>Is this medication effective?</i> <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective <i>Any side effects?</i> <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:			
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
<i>Is this medication effective?</i> <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective <i>Any side effects?</i> <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:			

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: None

Medication Name	Dosage	Frequency	Duration
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
<i>Is this medication effective?</i> <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective <i>Any side effects?</i> <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:			

OTHER CURRENT MEDICATIONS: _____

PAST ADHD MEDICATIONS IN LAST 2 YEARS:

Medication Name: _____ Dose: _____ mg _____ mg _____ mg

Side Effects (if any): _____

 How effective was this medication? not effective somewhat effective effective very effective

Medication Name: _____ Dose: _____ mg _____ mg _____ mg

Side Effects (if any): _____

 How effective was this medication? not effective somewhat effective effective very effective

Medication Name: _____ Dose: _____ mg _____ mg _____ mg

Side Effects (if any): _____

 How effective was this medication? not effective somewhat effective effective very effective

Patient Name: _____

- What are your main concerns today? (i.e. inattention, distractibility, hyperactivity, impulsivity, academic problems oppositional behaviors, etc.) _____

FAMILY HISTORY:

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

Condition	Mother	Father	Sibling	Sibling 2	Grandparent	Aunt/Uncle
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Mood Disorder						
Bipolar Disorder						
Depression						
Schizophrenia/Nervous Breakdown						
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 (for the patient):

- 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? Term Premature Overdue Induced # 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

Developmental History:

Please mark when you achieved the following milestones (E = early, A = average, or L = late) as compared to others your age (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:

- Did 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 feel tired during the day? Yes No
- Do you fall asleep during the day? Yes No

Behavioral/Mental Health History:

- Have you ever been formally diagnosed with ADHD? Yes No

If yes, when were you diagnosed and by whom? _____

 - Do you have documentation of the diagnosis? Yes No
 - Are you currently under a provider's care for ADHD? Yes No
 - If yes, name of provider: _____
 - What are your reasons for changing ADHD care providers? _____

Patient Name: _____

- Have you ever received IQ or Academic testing? Yes No
If yes, what were the results? Dyslexia Learning Disability Other: _____
- Have you ever participated in counseling, behavioral modification, or therapy? Yes No
If so, please explain:

- Have you ever experienced 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:

- 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
- Are you pregnant or nursing? Yes No

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

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Cardiac Abnormality	<input type="checkbox"/> Asthma/Allergies
<input type="checkbox"/> Enuresis or bedwetting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Constipation/Diarrhea
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Frequent Ear Infections
<input type="checkbox"/> Reflux	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Other:
If yes, please explain:		

SURGICAL HISTORY:

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

SOCIAL HISTORY:

- Parent 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
If you live with one parent, how often do you see the non-custodial parent?
 Frequently/equally At least weekly Rarely No relationship
 Every other week Monthly Less than monthly
- Do you have a consistent nighttime routine? Yes No
 TV in bedroom Watch TV/uses electronics before bedtime
 Usual bed time: _____ Usual wake time: _____
- 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
 Somewhat of a problem Moderate Problem Significant Problem
- Have you ever failed a grade or been held back? Yes No Yes, Explain _____
- 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: _____
- Do you have any special interests or hobbies? Yes No
 Sports/Fitness Hunting/fishing/outdoors
 Music/Band Video games _____ hours per day
 Drama/Dance Social media/blogging _____ hours per day
 Martial arts TV/other media _____ hours per day
 Art/creative writing Total electronic/media time _____ hours per day

- 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

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

- Do you work? 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
 - Somewhat of a Problem
 - Conflict with siblings
 - Step-parent/child conflict
 - Conflict with other family members
 - Moderate Problem
 - Significant problem

- How are your relationships with your peers?
 - I have several friends
 - I don't really have close friends
 - Significant conflict
 - Somewhat of a Problem
 - Limited friendships
 - Some conflicts
 - Problems making/keeping friends
 - Moderate Problem
 - Significant problem

- Have you had any issues with bullying?
 - No problems
 - I have bullied others
 - Bullying is being addressed
 - Somewhat of a Problem
 - I have been teased/picked on
 - Bullying is ongoing
 - 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: _____

