



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 Mt Pleasant
900 Bowman Rd, Suite 303
Mt Pleasant, SC 29464
Phone: 843-593-9332
Fax: 877-646-4360

Help Us Get to Know You

Please complete this questionnaire.

What do you do well?

What do you enjoy doing most?

How long have you been experiencing ADHD type symptoms?

Do you avoid talking on the phone?

Can you drink caffeine without it affecting your sleep?

Do you re-read paragraphs or pages because you didn't get it 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?

Are you frequently late for appointments?

Do you have significant time management problems? Is procrastination a problem for you?

Do you get frustrated and overwhelmed with school work, housework, your job, or other responsibilities?

Are you sensitive to noise, light, textures/touch?

Are you a worrier?

Do you feel unhappy a lot?

Do you have trouble making/keeping friends?

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

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Duration</u>
	_____ 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

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Duration</u>
	_____ 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

FAMILY HISTORY:

- Is your mother living? Yes, age: _____ No, age and cause of death: _____
- Is your father living? Yes, age: _____ No, age and cause of death: _____

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	Children	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:
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, who is your current ADHD care provider? _____
 - What are your reasons for changing ADHD providers? _____

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

<input type="checkbox"/> Counseling	<input type="checkbox"/> Behavioral Modification	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Reading Intervention	<input type="checkbox"/> Special Education

 Do you have any history of the following? Yes No

<input type="checkbox"/> Learning Disorder	<input type="checkbox"/> Anxiety, Panic Attacks	<input type="checkbox"/> OCD
<input type="checkbox"/> Mood Disorder/Bipolar	<input type="checkbox"/> Depression	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Tics/Tourette's	<input type="checkbox"/> Autism/Asperger's	<input type="checkbox"/> Substance Abuse/Addiction

Sleep History:

 • Did you have a history of sleeping problems? Yes No

- | | |
|---|---|
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Talking in sleep | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Walking in sleep | <input type="checkbox"/> Vivid dreams |

 • Have you gone longer than 24 hours without sleep? Yes No

 If yes, were you tired the next day? Yes No If so, 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 fall asleep during the day? Yes No

General Medical History:

 Are you pregnant or nursing? Yes No

 Do you have any history of the following? Yes No

<input type="checkbox"/> Hypertension	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Seizure Activity
<input type="checkbox"/> Stroke	<input type="checkbox"/> Syncope/Fainting	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD	<input type="checkbox"/> Head Injury Date: _____	<input type="checkbox"/> Cardiac Abnormality
<input type="checkbox"/> Migraine	<input type="checkbox"/> Headaches	<input type="checkbox"/> Reflux
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sleep Disordered Breathing
<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Other:	

<input type="checkbox"/> Normal Vision	<input type="checkbox"/> Vision Impaired	<input type="checkbox"/> Contacts	<input type="checkbox"/> Glasses
<input type="checkbox"/> Normal Hearing	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Other:

SURGICAL HISTORY:

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Gall Bladder Removed
<input type="checkbox"/> Tubes in ears	<input type="checkbox"/> Other:	

SOCIAL HISTORY:

- What is your marital status?
 - Married Never married Divorced
 - Separated Widowed Partner
- With whom do you live?
 - Alone Spouse/partner Spouse/partner and children
 - Sibling Relatives Roommate/friend
- 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 Associate's Degree
 - Bachelor's Degree Master's degree Doctorate or Law degree
- Are you currently in college? Yes No
 - Freshman Sophomore Junior Senior Grad School
- Do/did you have any of the following problems while in school?
 - Attention problems Difficulty reading Poor school performance
 - Discipline problems Difficulty w/math Work hard w/inferior results
 - Under performance Turned in work late
- Did you have any academic support/accommodations while in school? Yes No
- Were you ever held back or failed a grade? Yes No Explain: _____
- What is your employment status?
 - Full-time Part-time Per diem/contract
 - Seasonal Retired Change jobs frequently
 - Disabled Unemployed Problems with work performance
- What type of work do you do? _____
- Do you exercise regularly? Yes No
 - Aerobic Weight lifting Flexibility Stability Strength training
- How would you classify your diet? Regular Vegetarian Other dietary restrictions _____
- List activities that you enjoy doing: _____
- What is your general stress level? Low Medium High Average Worsening Improving

- In the past year, have you had any recent life stressors?
 - None
 - Change in family dynamic
 - Job Instability
 - Loss of relationship
 - Loss of loved one
 - Empty Nest
 - Marriage
 - Significant health diagnosis
 - Job loss
 - Relocation
 - Loss of relationship
 - New relationship
 - Divorce
 - Financial problems
 - Loss of loved one
 - Academics/return to school
 - Retirement

- 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

- 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
 - Several drinks daily
 - Once a day
 - A few days a week
 - On weekends/socially
 - Rarely
 - Concern for addiction

- Do you use chewing tobacco/smoke? Yes No
 - More than one pack a day
 - Several daily
 - A few days a week
 - On weekends/socially

- Do you use marijuana? Yes No
 - Infrequent
 - Frequent
 - Concern for addiction

- Have you used other drugs? Yes No
 - Cocaine
 - Xanax
 - Narcotics
 - Amphetamines
 - Other
 - Infrequent
 - Frequent
 - Concern for addiction

- Do you participate in any type of rehab program or substance abuse counseling? Yes No

- Do you have any legal issues? Yes No