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 Richmond
9137 Chamberlayne Rd, Suite 107
Mechanicsville, VA 23116
Phone: 804-723-4668
Fax: 877-336-6301

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Patient Name: ___________________________

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?

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Patient Name: ___________________________

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

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Patient Name: ___________________________

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	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? *Any side effects?*	☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective ☐ No ☐ If yes, please describe:		
	_____ mg _____# tabs Time taken: ______ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? *Any side effects?*	☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective ☐ No ☐ If yes, please describe:		

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: ☐ **None**

Medication Name	***Dosage***	***Frequency***	***Duration***
	_____ mg _____# tabs Time taken: ______ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? *Any side effects?*	☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective ☐ No ☐ 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

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Patient Name: ___________________________

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? ___________________________________

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Patient Name: ___________________________

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

☐	Counseling	☐	Behavioral Modification	☐	Occupational Therapy
☐	Speech Therapy	☐	Reading Intervention	☐	Special Education

Do you have any history of the following? ☐ Yes ☐ No

☐	Learning Disorder	☐	Anxiety, Panic Attacks	☐	OCD
☐	Mood Disorder/Bipolar	☐	Depression	☐	Schizophrenia
☐	Tics/Tourette's	☐	Autism/Asperger's	☐	Substance Abuse/Addiction

Sleep History:

- Did you have a history of sleeping problems? ☐ Yes ☐ No
  ☐ Trouble falling asleep ☐ Trouble staying asleep
  ☐ Talking in sleep ☐ Frequent nightmares
  ☐ Walking in sleep ☐ 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

☐	Hypertension	☐	High Cholesterol	☐	Heart Attack
☐	Heart Murmur	☐	Arrhythmia	☐	Seizure Activity
☐	Stroke	☐	Syncope/Fainting	☐	Thyroid Disease
☐	Diabetes	☐	Cancer	☐	Asthma
☐	COPD	☐	Head Injury Date: ______	☐	Cardiac Abnormality
☐	Migraine	☐	Headaches	☐	Reflux
☐	Allergies	☐	Arthritis	☐	Sleep Disordered Breathing
☐	Restless Leg Syndrome	☐	Other:		

☐	Normal Vision	☐	Vision Impaired	☐	Contacts	☐	Glasses
☐	Normal Hearing	☐	Hearing Impaired	☐	Hearing Aids	☐	Other:

<u>SURGICAL HISTORY:</u>

☐	Tonsillectomy	☐	Appendectomy	☐	Orthopedic Surgery
☐	Adenoidectomy	☐	Hysterectomy	☐	Gall Bladder Removed
☐	Tubes in ears	☐	Other:		

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Patient Name: ____________________________

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

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Patient Name: ___________________________

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

☐ None ☐ Marriage ☐ Divorce
☐ Change in family dynamic ☐ Significant health diagnosis ☐ Financial problems
☐ Job Instability ☐ Job loss ☐ Loss of loved one
☐ Loss of relationship ☐ Relocation ☐ Academics/return to school
☐ Loss of loved one ☐ Loss of relationship ☐ Retirement
☐ Empty Nest ☐ New relationship

- What is your driving history?

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

- 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