



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 your child 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 your child is 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 are here to work with you to find the right solution. No one wants to change their child's 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 your child.

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 your child is making progress in reaching their 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:

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

Help Us Get to Know Your Child

Parents, **please have your child complete** this questionnaire or ask questions and quote answers directly if child can't complete independently.

What do you do well?

What do you enjoy doing most?

What is your favorite thing about school?

What is your least favorite thing about school?

Is it hard for you to sit still?

Is it hard to wait your turn? If you have to wait in line, or if you want to give an answer, is that hard for you?

Does your teacher think you talk too much?

Is it hard to pay attention to the teacher?

Is it hard to keep up with things like pencils, books, jackets, or sports equipment?

Is homework hard to finish?

Do you or your parents ever cry or yell over doing homework?

Do you have a good friend at school?

Do you worry a lot?

Are you sad a lot?

Name of Person Completing These Forms: _____ 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:

Does the child have any drug allergies? Yes No

If so, please name and describe the reaction: _____

The reaction is Mild Moderate Severe

Does the child 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 |
| Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective | | | |
| Any side effects? <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 |
| Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective | | | |
| Any side effects? <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 |
| Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective | | | |
| Any side effects? <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

- What are your main concerns regarding the patient?
(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: _____

| | 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 the child achieved the following milestones (E = early, A = average, or L = late) when compared to others his/her 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

Has there been any regression? _____

Sleep History:

- Does the child 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 child gone longer than 24 hours without sleep? Yes No

If yes, did the child seem tired the next day? Yes No

How often has this occurred? _____

What is the maximum number of days the child has gone without sleep? _____
- Does the child sleep after school? No Yes, Daily Yes, Occasionally How long? _____
- Does the child seem tired during the day? Yes No
- Does the child fall asleep during the day? Yes No

Behavioral/Mental Health History:

- Has the child ever been formally diagnosed with ADHD? Yes No

If yes, when was he/she diagnosed and by whom? _____

 - Do you have documentation of the diagnosis? Yes No
 - Is child currently under a provider's care for ADHD? Yes No
 - If yes, name of provider: _____

Why are you changing ADHD providers? _____

- Has the child ever received IQ or Academic testing? Yes No
 - Diagnosed with Dyslexia Learning Disability Other Diagnosis _____
- Has the child ever participated in counseling, behavioral modification, or therapy? Yes No
If so, please explain:

- Has the child every 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:

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

Please check if the child has 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 (daytime accidents) | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Encopresis (soiling w/stool) |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Reflux | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Diabetes | Other: _____ | |

SURGICAL HISTORY:

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

SOCIAL HISTORY:

- Is the patient your biological child? Yes No If adopted, at what age? _____
- Has the child ever been the victim of abuse or neglect? Yes No
- Parent 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
If child does not live with both parents, how often does the child see the non-custodial parent?
 Frequently/equally At least weekly Rarely No relationship
 Every other week Monthly Less than monthly
- Does the child 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 child have any dietary restrictions? Yes, Explain. _____
 Regular diet Vegetarian Other _____
- How would you rate the child's physical activity level?
 Very active Active Somewhat active Not active/ "couch potato"
- How many caffeinated beverages does the child drink each day?
 None <1 1-3 per day 3+ per day
- Where does the child attend school? _____ Grade: _____
- How is the child'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 child's school behavior? Good Disruptive Oppositional Meltdowns Other
 No problem Somewhat of a problem Moderate problem Significant problem
- Does the child receive any school based accommodations? Yes No Needed, but reluctant to use

| | |
|---|---|
| <input type="checkbox"/> Resource classroom | <input type="checkbox"/> Individual testing |
| <input type="checkbox"/> IEP | <input type="checkbox"/> Reduced work volume |
| <input type="checkbox"/> 504 Plan accommodation | <input type="checkbox"/> Response to intervention |
| <input type="checkbox"/> Extended time on testing | <input type="checkbox"/> Informal accommodations |
| <input type="checkbox"/> Testing in a quiet environment | <input type="checkbox"/> Other: _____ |
- Has the child failed a grade or been held back? Yes No If yes, which grade? _____
- Does the child have any hobbies or activities they enjoy?

| | |
|---|---|
| <input type="checkbox"/> Sports/athletics | <input type="checkbox"/> Hunting/Fishing/Outdoors |
| <input type="checkbox"/> Music/Band | <input type="checkbox"/> Video Games _____ Hours per day |
| <input type="checkbox"/> Drama | <input type="checkbox"/> Social Media _____ Hours per day |
| <input type="checkbox"/> Martial arts | <input type="checkbox"/> TV/Other Media _____ Hours per day |
| <input type="checkbox"/> Art/Creative writing | <input type="checkbox"/> School Clubs/Social Clubs |
| <input type="checkbox"/> Electronic/Media time is a problem | _____ Hours per day total electronic time |
- Describe the child's after school routine:

| | |
|--|--|
| <input type="checkbox"/> Tutoring/Educational Intervention | <input type="checkbox"/> After school care |
| <input type="checkbox"/> Unstructured | <input type="checkbox"/> Car Rider |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Rides Bus |
| <input type="checkbox"/> Homework is done after school | <input type="checkbox"/> Homework is delayed until evening |

- How is the child's behavior at home?
 - Good behavior
 - Problems with time management
 - Problems with task completion
 - Meltdowns
 - Homework problems
 - Oppositional behavior
 - Disrespectful behavior

Somewhat of a problem Moderate problem Significant problem

- How are the child's relationships with family members?
 - No unusual stress
 - Parent/child conflict
 - Conflict with non-custodial parent
 - Conflict with other family members
 - More than usual conflict with siblings
 - Step-parent/child conflict
 - Conflict with custodial parent/guardian

Somewhat of a problem Moderate problem Significant problem

- How are the child's relationships with peers?
 - Healthy, identifies friends
 - Doesn't identify friends
 - Significant conflict
 - Limited friendships
 - Some conflicts
 - Problems making/keeping friends

Somewhat of a problem Moderate problem Significant problem

- Have there been any bullying issues?
 - No problems
 - Child bullies others
 - Bullying is being addressed
 - Child is teased/picked on
 - Bullying is ongoing

Somewhat of a problem Moderate problem Significant problem

- Have there been any major stressors for the patient during the past year?
 - 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: _____