



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 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
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

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

<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: _____
- Do you have any special interests or hobbies? Yes No

<input type="checkbox"/> Sports/Fitness	<input type="checkbox"/> Hunting/fishing/outdoors
<input type="checkbox"/> Music/Band	<input type="checkbox"/> Video games _____ hours per day
<input type="checkbox"/> Drama/Dance	<input type="checkbox"/> Social media/blogging _____ 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"/> Total electronic/media time _____ hours per day

- Describe your after school routine:

<input type="checkbox"/> Tutoring/educational intervention	<input type="checkbox"/> School sponsored club/extracurricular
<input type="checkbox"/> After school job	<input type="checkbox"/> School sports team
<input type="checkbox"/> Volunteer	<input type="checkbox"/> Rides bus
<input type="checkbox"/> Complete homework after school	<input type="checkbox"/> Car rider/I drive to school
<input type="checkbox"/> Homework completed in evening	

- How is your behavior at home?

<input type="checkbox"/> Good behavior	<input type="checkbox"/> Homework problems
<input type="checkbox"/> Problems with time management	<input type="checkbox"/> Oppositional behavior
<input type="checkbox"/> Problems with task completion	<input type="checkbox"/> Disrespectful behavior
<input type="checkbox"/> Meltdowns	
<input type="checkbox"/> Somewhat of a Problem <input type="checkbox"/> Moderate Problem <input type="checkbox"/> Significant problem	

- Do you work? No Yes, Part Time Yes, Full Time Type of work? _____

- How is your relationship with your family?

<input type="checkbox"/> No unusual stress	<input type="checkbox"/> Conflict with siblings
<input type="checkbox"/> Conflict with parent(s)	<input type="checkbox"/> Step-parent/child conflict
<input type="checkbox"/> Conflict with non-custodial parent	<input type="checkbox"/> Conflict with other family members
<input type="checkbox"/> Somewhat of a Problem <input type="checkbox"/> Moderate Problem <input type="checkbox"/> Significant problem	

- How are your relationships with your peers?

<input type="checkbox"/> I have several friends	<input type="checkbox"/> Limited friendships
<input type="checkbox"/> I don't really have close friends	<input type="checkbox"/> Some conflicts
<input type="checkbox"/> Significant conflict	<input type="checkbox"/> Problems making/keeping friends
<input type="checkbox"/> Somewhat of a Problem <input type="checkbox"/> Moderate Problem <input type="checkbox"/> Significant problem	

- Have you had any issues with bullying?

<input type="checkbox"/> No problems	<input type="checkbox"/> I have been teased/picked on
<input type="checkbox"/> I have bullied others	<input type="checkbox"/> Bullying is ongoing
<input type="checkbox"/> Bullying is being addressed	
<input type="checkbox"/> Somewhat of a Problem <input type="checkbox"/> Moderate Problem <input type="checkbox"/> Significant problem	

- Have there been any major stressors in the past year? Yes No

<input type="checkbox"/> Family conflict	<input type="checkbox"/> Absent parent
<input type="checkbox"/> Peer relationships	<input type="checkbox"/> Serious illness in the family
<input type="checkbox"/> School performance	<input type="checkbox"/> Death in the family
<input type="checkbox"/> Sibling relationships	<input type="checkbox"/> Natural disaster
<input type="checkbox"/> Financial stressors	<input type="checkbox"/> Loss of housing
<input type="checkbox"/> Substance abuse in home	<input type="checkbox"/> Other: _____

