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

Patient Name: _____

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?

Patient Name: _____

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

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? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ 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? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ 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? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ 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

- 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						

Patient Name: _____

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

☐	Heart Murmur	☐	Cardiac Abnormality	☐	Asthma/Allergies
☐	Enuresis or bedwetting	☐	Seizures	☐	Constipation/Diarrhea
☐	Diabetes	☐	Thyroid Problems	☐	Frequent Ear Infections
☐	Reflux	☐	Headaches/Migraines	☐	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: _____

Patient Name: _____

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

Patient Name: _____

- 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
  - ☐ Homework problems
  - ☐ Oppositional behavior
  - ☐ Disrespectful behavior
  - ☐ Somewhat of a Problem ☐ 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
  - ☐ Conflict with siblings
  - ☐ Step-parent/child conflict
  - ☐ Conflict with other family members
  - ☐ Somewhat of a Problem ☐ Moderate Problem ☐ Significant problem

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

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

Patient Name: _____

- 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

  ☐ Infrequent ☐ Frequent ☐ Abuse ☐ Concern for addiction

- Do you use chewing tobacco/smoke? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Do you use marijuana? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Have you used other drugs? ☐ Yes ☐ No

  ☐ Cocaine ☐ Xanax ☐ Narcotics ☐ Other

- 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

- Do you have any legal issues? ☐ Yes ☐ No

  ☐ Minor w/possession of alcohol
  ☐ Vandalism
  ☐ Stealing/shoplifting
  ☐ Other charges
  ☐ On probation
  ☐ Possession of drugs
  ☐ Truancy
  ☐ Fighting/assault
  ☐ Prior incarceration
  ☐ Off probation