Name: _____ Date of Birth: ___/___/_____

Name you go by: _____

New Patient 18+

Thank you for completing this packet. Your input is important and having this information before your appointment helps us use the time during your visit more efficiently to better address your concerns.

- Complete the information completely giving as much detail as possible.
- Be honest. We do not disclose this information to anyone without your consent.
- It is important for us to know what medications you take and other conditions you have so we can make the best decisions about your condition and care.
- Don't worry about answering the questions incorrectly or be concerned that you might 'label' yourself. There are no right or wrong answers.
- If you are unsure of an answer, provide an answer which best describes you a good deal of the time in that situation.
- It may seem like we are asking for a lot of information about you, however, it is important for us to have this information, so we can be as comprehensive and accurate as possible with our diagnosis.

To start, tell us your specific concerns about symptoms and problems you are having that you want to make sure we cover during your appointment?

REVIEW OF SYSTEMS:

Constitutional

☐ Yes ☐ No Daytime sleepiness/fatigue
☐ Yes ☐ No Problems Falling Asleep
☐ Yes ☐ No Problems Staying Asleep
☐ Yes ☐ No Decreased Appetite at lunch
☐ Yes ☐ No Decreased Appetite all day
☐ Yes ☐ No Weight Gain
☐ Yes ☐ No Weight Loss

Eyes

☐ Yes ☐ No Frequent Blinking/Squinting
☐ Yes ☐ No Itching/Rubbing Eyes
☐ Yes ☐ No Vision Problems-**other than glasses/contacts**

Ears/Nose/Throat

☐ Yes ☐ No Large Tonsils
☐ Yes ☐ No Snoring
☐ Yes ☐ No Hearing Loss

Respiratory

☐ Yes ☐ No Frequent Cough
☐ Yes ☐ No Cough at Night/Wakes Patient
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Tightness in Chest

Heart/Vascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Heart Racing/Fast Heart Rate
☐ Yes ☐ No High Blood Pressure

Gastrointestinal

☐ Yes ☐ No Frequent Abdominal Pain
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Stool Leakage/Accidents
☐ Yes ☐ No Constipation
☐ Yes ☐ No GERD/Reflux/Frequent Heartburn
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Blood in Stool

Genito/Urinary

☐ Yes ☐ No Bed Wetting
☐ Yes ☐ No Urine Accident/Incontinence
☐ Yes ☐ No Frequent Urinating
☐ Yes ☐ No Irregular, Heavy Period
☐ Yes ☐ No Significant Menstrual Pain

Skin/Hair/Nails

☐ Yes ☐ No Sores or Rashes
☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Twirls or Pull Hair
☐ Yes ☐ No Skin picking
☐ Yes ☐ No Nail biting or picking cuticles

Neurological

☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Verbal Tics – Sniffing, Throat Clearing, Vocalizing
☐ Yes ☐ No Motor Tics – Blinking, Jerking
☐ Yes ☐ No Tremor
☐ Yes ☐ No Blank Staring Spells
☐ Yes ☐ No Seizures
☐ Yes ☐ No Weakness

Musculoskeletal

☐ Yes ☐ No Limp or Gait Disturbance
☐ Yes ☐ No Clumsy
☐ Yes ☐ No Joint Pain

Endocrine

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Problems with Growth/Short Stature
☐ Yes ☐ No Frequent Urination/Drinks Excessive Fluids
☐ Yes ☐ No Thyroid Problems

Heme/Lymph

☐ Yes ☐ No Anemia
☐ Yes ☐ No Easily Bruised

Allergic/Immunologic

☐ Yes ☐ No Asthma
☐ Yes ☐ No Eczema

Psychiatric

☐ Yes ☐ No Anxious, Worries
☐ Yes ☐ No Aggression
☐ Yes ☐ No Apathetic/Lazy
☐ Yes ☐ No Cutting Behaviors
☐ Yes ☐ No Depressed, Sad
☐ Yes ☐ No Overly Confident or Grandiose thoughts
☐ Yes ☐ No Flat Effect/Zombie-like
☐ Yes ☐ No Frequent Anger
☐ Yes ☐ No Increase desire for sex/sex drive above your norm
☐ Yes ☐ No Irritable, Touchy
☐ Yes ☐ No Low frustration tolerance
☐ 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 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 Thoughts of Self Harm, Suicide
☐ Yes ☐ No Attempts at Self Harm, Suicide

ALLERGIES (list all food, drug, environmental *and* reaction if known):

Allergan (ex. Penicillin, latex)	**Reaction (ex. Rash, Anaphylaxis)**
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS (*OTHER than* ADHD meds-include supplements and meds for all other medical issues):

_____	_____
_____	_____
_____	_____

CURRENT *ADHD* MEDICATIONS*:*

Medication Name	**Dose**	**Effectiveness**	**Side effects**	**How Long on Current Dose**

PAST ADHD and/or **other Mental Health** MEDICATIONS**:**

Medication Name	**Dose**	**Effectiveness**	**Side effects**	**How long Did You Take Medication**
ex. Adderall XR 20 mg		**worked well**	**headaches**	**3 years**

Have you ever been previously diagnosed with ADHD? ☐ Yes ☐ No If yes, When/What age? _____

At what age (**or approximately when**) did you or other become aware of attention/hyperactive symptoms in yourself?

☐ age 0-5
☐ age 6-9
☐ age 10-12
☐ age 13-18
☐ age 18-21
☐ age 21-25
☐ age 26-35
☐ age 36+

_____

In what areas of your life do ADHD symptoms cause problems for you?

☐ Home (ex. bills, organization, cleaning, run of house)
☐ Work (performance, multiple jobs, enjoyment)
☐ School behavior (**current and/or past**)
☐ School performance (**current and/or past**)
☐ Homework (**current and/or past**)
☐ Driving
☐ Family Relationships (parent/sibling/sig. other)
☐ Peer relationships (work/friends)
☐ Other social:_____
☐ Other areas: _____

D0/DID you have any of the following problems while in school?

- ☐ Attention Problems
- ☐ Difficulty Reading
- ☐ Discipline Problems
- ☐ Poor School Performance
- ☐ Difficulty with Math
- ☐ Work Hard w/Inferior Results
- ☐ Worked LONGER on projects/homework than others
- ☐ Under Performance
- ☐ Turned in Work Late
- ☐ I got good grades in grade school without studying much

Have you been diagnosed with any other learning problems? ☐ Yes ☐ No
Explain: _____

DO/DID you have any accommodations at school? (ex. IEP, 504 plan, extra time for exams) ☐ Yes ☐ No
If yes, explain: _____

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

□	ADHD Coaching/counseling	□	Behavioral Modification	□	Occupational Therapy
□	Speech Therapy	□	Reading Intervention	□	Special Education

Think about your life. Do you feel you have always been more sensitive than other people you know to rejection, teasing, criticism, or your own perception that you have failed or fallen short? ☐ Yes ☐ No

Explain further, if needed:

Have you been diagnosed with any of the following conditions? ☐ Yes ☐ No

- ☐ Learning Disorder (specify: _____)
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Disorder/panic attacks
- ☐ Bipolar Disorder
- ☐ Eating Disorder (specify: _____)
- ☐ OCD
- ☐ Tics/Tourette Syndrome
- ☐ Autism Spectrum
- ☐ Substance Abuse
- ☐ **Other** mental health issue: _____

Treatment/therapies for any of the above:

FAMILY HISTORY:

Please indicate with a √ if any of your immediate family members have experienced any of the following conditions.
Initial if no significant family health issues known: _____

□ Adopted. Unaware of Biological family history

	Mother	Father	Sibling	Children	Grandparent	other: list
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Bipolar Disorder						
Schizophrenia						
Depression						
Tics/Tourette						
Autism/Asperger						
Frequent Headaches/Migraines						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age of 40 (if yes, explain below)						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						

Other significant family mental health and/or medical conditions (if applicate):

MEDICAL HISTORY:

Sleep History:

Do you have a history of sleep problems? □ Yes □ No

□ Trouble falling asleep □ Trouble staying asleep □ Vivid dreams □ Sleep Apnea
□ Talking in sleep □ Frequent nightmares □ Walking in sleep

How long does it take you to fall asleep? _____
How many hours/night do you typically sleep? _____
How many hours would you *LIKE* to sleep a night/try to sleep a night? ____

Do you feel tired during the day? □ Yes □ No Do you nap during the day? □ Yes □ No

Have you gone more than 24 hours without sleep? □ Yes □ No
If yes, were you tired the next day? □ Yes □ No
How often has this occurred? _____
Was it Work or School Related? □ Yes □ No
What is the maximum number of HOURS you have gone without sleep? _____

Check if you have any of the following conditions: □ **No on-going medical problems**

□	Hypertension	□	High Cholesterol	□	Heart Attack
□	Heart Murmur	□	Arrhythmia	□	Heart Abnormality
□	Stroke	□	Fainting	□	Thyroid Disease
□	Diabetes	□	Cancer	□	Asthma
□	COPD	□	Head Injury Date: _____	□	Seizure Disorder
□	Migraine	□	Headaches	□	Reflux
□	Arthritis	□	Restless Legs Syndrome	□	Sleep Disordered Breathing/apnea
□	***Other:***				

□	Normal Vision	□	Glasses	□	Contacts	□	Other Vision Impairment
□	Normal Hearing	□	Hearing Impaired	□	Hearing Aids		

SURGICAL HISTORY: (Procedure and Date ex: appendectomy 2000)

_____ _____

_____ _____

SOCIAL HISTORY: (answer as applies to you)

How do you classify yourself? □ Married □ Single-never married □ Divorced □ Separated □ Widowed
□ Partner/Significant Other □ Other: _____

With whom do you live? □ Myself □ Spouse/Significant Other □ Spouse/Partner & Children □ Boy Friend □ Girl Friend □ Parents □ Roommate □ Friend □ Other: _____

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 □ Still working on degree □ Associate Degree □ Bachelor's Degree
□ Master's degree □ Doctorate □ Working on degree (specify: _____)

Are you currently in school? □ Yes □ No Where do you attend school? _____

What year are you in your studies? _____ Field of Study: _____

If you have a job, what type of Work do you do? _____ Duration at current job: _____

What is your employment status? □ FT □ PT □ Temp □ Seasonal □ Retired □ Unemployed □ Disabled

Do you exercise regularly? □ Yes □ No What do you like to do for exercise? _____

How do you classify your diet? (Ex. Regular, vegan, low carb, Keto, etc) _____

What is your general stress level? □ Low □ Medium □ High □ Average □ Worsening □ Improving

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

□ None	□ Marriage	□ New Relationship	□ Divorce
□ Significant health diagnosis	□ Retirement	□ School/Academics	□ Loss of Relationship
□ Job instability	□ Job loss	□ Relocation	□ Loss of loved one

□ Other: _____

What is your driving history? □ No moving traffic violations □ No accidents
____Moving traffic violations in past 5 years #____ Motor vehicle accidents in past 5 years

Past or present legal issues: □ None □ Past Legal troubles □ Current Legal troubles
Explain: _____

How many caffeinated beverages do you consume a day? □ None □ <1 per day □ 1-3 per day □ 3+ per day
(What is your caffeine drink of choice? _____)

Do you use alcohol? □ Yes □ No Do you feel you have a problem with alcohol? □ Yes □ No
□ Several drinks daily □ One a day □ A few days a week □ Weekends/socially □ Binge drinking

Do you use tobacco products? ☐ Yes ☐ No ☐ cigarettes ☐ e-cigs ☐ chewing tobacco ☐ other
How often do you use tobacco products: ☐ Daily use LESS than PPD ☐ Daily use MORE than a PPD ☐ Occasional ☐ Social/weekend use

Do you use street/illicit drugs? ☐ Yes ☐ No Do you feel you have a problem with illicit drugs? ☐ Yes ☐ No
Substance(s) used: (Ex. pot, cocaine, heroin, etc.) _____
How often do you use these substances? ☐ Infrequent ☐ Frequent ☐ Regularly ☐ Other_____

Have you ever had an issue with misuse/abuse of prescription drugs? Ex: stimulants, narcotics, benzodiazepines
☐ Yes ☐ No
Have you ever needed any sort of treatment for drug abuse/misuse? ☐ Yes ☐ No
☐ Inpatient Care ☐ Outpatient Care ☐ Suboxone or other medicine management

Please complete the following screens

In the past two weeks, how often have you been bothered by the following problems?
0 – Not at all 1 – Several days 2 – More than half the days 3 – Nearly every day

Symptom	GAD-7 Screen	Rating: 0 to 3 (see above)
Feeling nervous, anxious, or on edge		
Not being able to stop or control worrying		
Worrying too much about different things		
Trouble relaxing		
Being so restless that it is hard to sit still		
Becoming easily annoyed or irritable		
Feeling afraid as if something awful might happen		
TOTAL SCORE:		

H**ow difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely

Symptoms	PHQ-9 Screen	Rating 0 to 3 (see above)
Little interest or pleasure in doing things		
Feeling down, depressed, or hopeless		
Trouble falling or staying asleep, or sleeping too much		
Poor appetite or overeating		
Feeling tired, or having little energy		
Feeling bad about yourself — or that you are a failure or have let yourself or your family down		
Trouble concentrating on things, such as reading the newspaper or watching television		
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual		
Thoughts that you would be better off dead or of hurting yourself in some way		
TOTAL SCORE:		

H**ow difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely

Patient to Complete

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist						
Rate your ADHD symptoms. Mark the box that best describes how you have felt/behaved/conducted yourself over that past 6 months.	**Never**	**Rarely**	**Some-times**	**Often**	**Very Often**	
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						PART A
How often do you have difficulty getting things in order when you must do a task that requires organization?						
How often do you have problems remembering appointments or obligations?						
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
How often do you feel overly active and compelled to do things, like you were driven by a motor?						
How often do you make careless mistakes when you have to work on a boring or difficult project?						PART B
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
How often do you misplace or have difficulty finding things at home or at work?						
How often are you distracted by activity or noise around you?						
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
How often do you feel restless or fidgety?						
How often do you have difficulty unwinding and relaxing when you have time to yourself?						
How often do you find yourself talking too much when you are in social situations?						
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
How often do you have difficulty waiting your turn in situations when turn taking is required?						
How often do you interrupt others when they are busy?						

Other Adult well known to patient to complete (Ex. Spouse, sibling, parent, significant other)

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist						
Rate other person's ADHD symptoms. Mark the box that best describes how you perceive this person has behaved/conducted themselves over that past 6 months.	**Never**	**Rarely**	**Some-times**	**Often**	**Very Often**	
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						**PART A**
How often do you have difficulty getting things in order when you must do a task that requires organization?						
How often do you have problems remembering appointments or obligations?						
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
How often do you feel overly active and compelled to do things, like you were driven by a motor?						
How often do you make careless mistakes when you have to work on a boring or difficult project?						**PART B**
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
How often do you misplace or have difficulty finding things at home or at work?						
How often are you distracted by activity or noise around you?						
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
How often do you feel restless or fidgety?						
How often do you have difficulty unwinding and relaxing when you have time to yourself?						
How often do you find yourself talking too much when you are in social situations?						
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
How often do you have difficulty waiting your turn in situations when turn taking is required?						
How often do you interrupt others when they are busy?						

Name of person completing: _____ **relationship:** _____