Patient Name: _____ Date of Birth: _____

New Patient-Ages 4-12

Thank you for taking the time to complete 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.
- It is important to be honest. It is important for us to know what medications the patient takes and other conditions they have so we can make the best decisions about care.
- Don't worry about answering the questions incorrectly or be concerned that you might 'label' the patient. There are no right or wrong answers.
- If you are unsure of an answer, provide an answer which best describes the patient a good deal of the time in that situation.

It may seem like we are asking for a lot of information about, however, it is just our effort to be as comprehensive and accurate as possible with our diagnosis.

Name of person completing this form: _____
Relationship to patient: _____

What are your main concerns regarding the patient?
(i.e. inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behaviors, etc.):

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS: (Current problems)

Constitutional
- ☐ Yes ☐ No Problems Falling
- ☐ Yes ☐ No Problems Staying Asleep
- ☐ Yes ☐ No Daytime sleepiness
- ☐ Yes ☐ No Decreased Appetite at Lunch
- ☐ Yes ☐ No Decreased Appetite in general
- ☐ Yes ☐ No Weight Gain
- ☐ Yes ☐ No Weight Loss

Eyes
- ☐ Yes ☐ No Frequent Blinking/Squinting
- ☐ Yes ☐ No Vision Problems (**other than corrective lenses**)
- ☐ Yes ☐ No Itching/Rubbing Eyes

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/Heartburn
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Blood in Stool

Genito/Urinary
- ☐ Yes ☐ No Bed Wetting
- ☐ Yes ☐ No Urine Accident/Incontinence
- ☐ Yes ☐ No Irregular, Heavy Period, if applicable
- ☐ Yes ☐ No Significant Menstrual Pain, if applicable

Skin/Hair/Nails
- ☐ Yes ☐ No Sores or Rashes
- ☐ Yes ☐ No Hair Loss
- ☐ Yes ☐ No Acne
- ☐ Yes ☐ No Twirls or Pull Hair
- ☐ Yes ☐ No Picks/bites at Skin/Nails

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 Aggression
- ☐ Yes ☐ No Anxious, Worries
- ☐ Yes ☐ No Apathetic/Lazy
- ☐ Yes ☐ No Cutting Behavior
- ☐ Yes ☐ No Depressed, Sad
- ☐ Yes ☐ No Overly Confident or Grandiose thoughts
- ☐ Yes ☐ No Flat Effect/Zombie-like
- ☐ Yes ☐ No Frequent Anger
- ☐ Yes ☐ No Increased sex drive-above your norm
- ☐ Yes ☐ No Irritable, Touchy
- ☐ Yes ☐ No Low Frustration tolerance
- ☐ Yes ☐ No Low Self Esteem
- ☐ 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- i.e. 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):

_____

_____

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

_____ _____

_____ _____

_____ _____

CURRENT *ADHD* MEDICATIONS*:*

Medication Name_____Dose_____Effectiveness_____Side effects_____

_____

_____

_____

PAST ADHD MEDICATIONS:

Medication Name_____Dose_____Effectiveness_____Side effects_____

_____

_____

_____

ADHD History

- At what age did you first notice symptoms of ADHD? _____
- Has the patient ever been formally diagnosed with ADHD? ☐ Yes ☐ No
  If yes, when was the diagnosis made and by whom? _____
  - Do you have documentation of the diagnosis? ☐ Yes ☐ No
  - Is the patient currently under a provider's care for ADHD? ☐ Yes ☐ No

  Reasons for changing ADHD provider? _____
- Has the patient ever received IQ/Academic/psychoeducational testing? ☐ Yes ☐ No
  - **Diagnosis?** _____
- Has the patient 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

Any history of the following:

- ☐ Delayed expressive language
- ☐ Stuttering
- ☐ Problems articulating words
- ☐ Below grade level in Reading
- ☐ Below grade level in Math
- ☐ Trouble writing (messy handwriting and/or avoids writing)
- ☐ Underachieves academically relative to potential
- ☐ Variable performance

In what areas do you see inattention, hyperactivity, impulsivity affecting the patient?

- ☐ School behavior
- ☐ Academic performance/learning
- ☐ Peer relationships
- ☐ Home work
- ☐ Family relationships
- ☐ Extracurricular activities
- ☐ Sports
- ☐ Other _____

Does the patient experience 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

If yes to any of the above, has the patient received specific treatment for the condition? Explain:

_____

FAMILY HISTORY*:* Check all applicable (explain on back if needed)

☐ Patient was adopted, biologic family history unknown

	Mother	Father	Sibling(s)	Grandparen	Aunt/Uncle	Other family
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Bipolar Disorder						
Depression						
Schizophrenia						
Tics/Tourette's						
Migraine Headaches						
Autism Spectrum Disorder						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age of 40						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						
Asthma						
Other Significant Condition						

MEDICAL HISTORY:

Newborn History:

- 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: # 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

  ☐ Other: _____

Developmental History:

Mark when the patient achieved the following milestones (E = early, A = average, or L = late) compared to others (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 patient have a history of sleeping problems? □ Yes □ No
  □ Trouble Falling Asleep □ Trouble Staying Asleep □ Sleep Walking □ Talking in Sleep
  □ Frequent Nightmares □ Frequent Night Terrors □ Vivid Dreams
- Has the patient gone longer than 24 hours without sleep? □ Yes □ No
  If yes, did the patient seem tired the next day? □ Yes □ No
  How often has this occurred? _____
  What is the maximum number of hours the patient has gone without sleep? _____
- Does the patient sleep/nap during the day or after school? □ No □ Yes, Daily □ Yes, Occasionally
  How long does he/she sleep? _____
- Does the patient seem tired during the day? □ Yes □ No
- Does the patient nap during the day? □ Yes □ No

General Medical History:

- Hospitalizations: □ Yes □ No
  If yes, please explain: _____
- History of concussion or head injury? □ Yes □ No If yes, date: _____
- Vision? □ Normal □ Wear corrective lenses or contacts □ Other vision impairment
- Hearing? □ Normal □ Uses hearing aid □ Other hearing impairment

Please check if the patient has ever experienced any of the following symptoms or conditions: □ None

□	Heart Murmur	□	Cardiac Abnormality	□	Asthma
□	Enuresis (daytime accidents)	□	Bedwetting	□	Encopresis (soiling w/stool)
□	Constipation/Diarrhea	□	Thyroid Problems	□	Frequent Ear Infections
□	Seizures	□	Reflux	□	Frequent Headaches
□	Diabetes	Other:			

SURGICAL HISTORY:

Surgical Procedure and Date

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY:

- Is the patient your biological child? ☐ Yes ☐ No
- If adopted, when was the patient adopted (what age)? _____
    - How much do you know about the patient's biological family?

      _____
- Has the patient ever been the victim of abuse or neglect? ☐ Yes ☐ No
- Parents 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 ☐ Other _____

  If patient does not live with both parents, how often does the patient see the non-custodial parent?

  ☐ Frequently/equally ☐ At least weekly ☐ Rarely ☐ No relationship

  ☐ Every other week ☐ Monthly ☐ Less than monthly
- Does the patient 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 patient have any dietary restrictions? ☐ Yes, Explain. _____

  ☐ Regular diet ☐ Vegetarian ☐ Other _____
- How would you rate the patient's physical activity level?

  ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/couch potato
- How many caffeinated beverages does the patient drink each day?

  ☐ None ☐ <1 ☐ 1-3 per day ☐ 3+ per day
- Where does the patient attend school? _____ Grade: _____
- ☐ Public School ☐ Private School ☐ Home School ☐ Religious Affiliated School ☐ Charter School ☐ Other
- How is the patient'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 patient's school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns ☐ Other

  ☐ No problem ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Does the patient receive any school based accommodations? ☐ Yes ☐ No ☐ Needed
  - ☐ Resource classroom
  - ☐ IEP
  - ☐ 504 Plan accommodation
  - ☐ Extended time on testing
  - ☐ Individual testing
  - ☐ Reduced work volume
  - ☐ Testing in decreased distraction environment
  - ☐ Other: _____

- Describe the patient's hobbies/special interests (ex. Sports, music, art, fishing, etc.):

  _____

  _____

  _____

- How much time does the patient spend each day with the following:
  - ☐ Video Games: _____ hrs/day
  - ☐ TV: _____
  - ☐ Computer/social media: _____
  - ☐ Unstructured Playtime: _____
  - ☐ Homework: _____

- Describe the patient's after school routine:
  - ☐ Car Rider ☐ After school care ☐ Rides Bus ☐ Tutoring
  - ☐ Homework is done after school ☐ Homework is delayed until evening

  Other: _____
- How is the patient's behavior at home (check all that apply)?
  - ☐ Good behavior ☐ Homework problems ☐ Meltdowns
  - ☐ Problems with time management ☐ Oppositional behavior ☐ Problems with task completion
  - ☐ Disrespectful behavior
    - ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the patient'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 patient'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
  - ☐ Patient is teased/picked on
  - ☐ Patient bullies others
  - ☐ Bullying is ongoing
  - ☐ Bullying is being addressed
    - ☐ Somewhat of a problem
    - ☐ Moderate problem
    - ☐ Significant problem

- Have there been any major stressors for the patient during the past year?
  - ☐ Family conflict
  - ☐ Absent parent
  - ☐ Peer relationships
  - ☐ Serious illness in the family
  - ☐ School performance
  - ☐ Death in the family
  - ☐ Sibling relationships
  - ☐ Natural disaster
  - ☐ Financial stressors
  - ☐ Loss of housing
  - ☐ Substance abuse in home
  - ☐ Other: _____