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
3930-F Airport Blvd
Mobile, AL 36608
Phone: 251-378-8635
Fax: 877-392-5089

Patient Name: _____

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?

Patient Name: _____

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

Patient Name: _____

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	☐ 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

Patient Name: _____

- 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						

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 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? _____

Patient Name: _____

- 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

☐	Heart Murmur	☐	Cardiac Abnormality	☐	Asthma/Allergies
☐	Enuresis (daytime accidents)	☐	Bedwetting	☐	Encopresis (soiling w/stool)
☐	Constipation/Diarrhea	☐	Thyroid Problems	☐	Frequent Ear Infections
☐	Seizures	☐	Reflux	☐	Headaches/Migraines
☐	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

Patient Name: _____

- 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

  ☐ Resource classroom
  ☐ IEP
  ☐ 504 Plan accommodation
  ☐ Extended time on testing
  ☐ Testing in a quiet environment
  ☐ Individual testing
  ☐ Reduced work volume
  ☐ Response to intervention
  ☐ Informal accommodations
  ☐ 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?

  ☐ Sports/athletics
  ☐ Music/Band
  ☐ Drama
  ☐ Martial arts
  ☐ Art/Creative writing
  ☐ Electronic/Media time is a problem
  ☐ Hunting/Fishing/Outdoors
  ☐ Video Games _____ Hours per day
  ☐ Social Media _____ Hours per day
  ☐ TV/Other Media _____ Hours per day
  ☐ School Clubs/Social Clubs
  _____ Hours per day total electronic time

- Describe the child's after school routine:
  ☐ Tutoring/Educational Intervention
  ☐ Unstructured
  ☐ Volunteer
  ☐ Homework is done after school
  ☐ After school care
  ☐ Car Rider
  ☐ Rides Bus
  ☐ Homework is delayed until evening

Patient Name: _____

- 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: _____