Birmingham

Ph: 205-769-0649 Fax: 205-769-0657 eFax: 877-420-6670

NEW PATIENT INFORMATION FORM

How did you find out about us? ☐ Physician ☐ internet ☐ word of mouth ☐ Printed advertisement ☐ Transfer from other FocusMD location

Patient info:

Se at irt re ired r ne r sy i a t er is ed dia riteria

LEGAL NAME (w/MI): _____ ☐ Male ☐ Female

DOB: _____ Patient goes by: _____

Address/City/ST/ZIP: _____

Email Address: _____

Primary Phone Number: _____ Alt Phone Number: _____

Parent or Emergency Contact Name: _____

Emergency contact Phone#: _____ Relationship to Patient: _____

Primary care physician: _____

Preferred pharmacy (name and location): _____

Is your insurance: ☐ **employer-based** / ☐ **self-funded** / ☐ **a marketplace or ACA exchange plan**

Primary insurance:	**Secondary insurance:**
ID#	**ID#**
Group #	**Group #**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder DOB:	**Policy Holder DOB:**
Policy Holder relation to patient:	**Policy Holder relation to patient:**

Responsible Party: Name: _____ DOB: _____

Responsible Party SSN: _____ Responsible Party Phone: _____

Address (if different from patient): _____

Previously diagnosed (circle all that apply): ☐ NONE

☐ ADHD ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Other MH disorders

☐ Autism/Aspergers ☐ other LD/Dev delay ☐ Color blindness

☐ Heart conditions ☐ BP problems ☐ Seizures ☐ Other Major Medical ☐ Eyeglasses/contact use

☐ Antidepressants ☐ Anti-anxiety meds ☐ Stimulant or non-stimulant ADHD meds ☐ Other Rx meds

☐ Prior/current substance abuse ☐ Methadone/Suboxone

FOR OFFICE USE ONLY:	
☐ Verify Insurance	☐ Create chart and portal access
☐ Email portal access with registration instructions	☐ Verify completion of registration prior to reminder call

focusMD

Patient Acknowledgement of Privacy, Financial, and Practice Policies

Financial Policies

_____ (initial) I acknowledge I have received the Focus-MD Financial Policy

- Patient/guarantor is responsible for providing accurate insurance information
- Patient/guarantor is responsible for any authorization required by insurance companies
- Patient/guarantor understands additional fees may incur as described in policy

_____ (initial) I acknowledge I have received the Focus-MD Non-Covered Service Agreement

- Some services are not covered by insurance
- Any services not covered are the responsibility of the patient/guarantor

_____ (initial) Our Cancellation Policy

Our provider's time is reserved for you. We do not double book our patients in order to provide adequate time for each individual. We strive for exceptional care through individual attention.

- Any appointment cancelled *less than 24 hours in advance* is considered a No Show.
- A No Show on a new or extended patient appointment will result in a $100 fee that is not covered by insurance.
- A No Show on an established patient appointment will result in a fee of $30 that is not covered by insurance
- Exceptions to this policy will be reserved for verifiable emergencies only and will be at the sole discretion of management.
- Repeated No Show appointments will result in unconditional discharge from care at this facility.

Privacy Polices

_____ (initial) I acknowledge I have received the Focus-MD's Notice of Privacy Practices

- Our Notice of Privacy Practices provides information about how we use and disclose your PHI

_____ (initial) I acknowledge I have received the Consent of Use or Disclosure of PHI

We will not discuss your or your child's care with family or friend unless authorized in writing.

Please complete the following so that the individuals you specify can have access to your information.

I consent to disclosure of the following protected health information about my child/me to the following family member(s) or person(s) involved in the care or payment for my child's/my care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- In accordance with the law, your protected health information may be disclosed by us to effectively treat you, to get paid by your insurance company for your care, and to effectively operate our office.
- To effectively operate our office we may leave appointment reminders or other health care information via phone messages, email, text, and US mail.

_____ (initial) To ensure privacy, I agree to use the patient portal for questions pertaining to medical management and discussion of symptoms/side effects. I understand that this communication is a part of the patient's permanent medical record.

_____ (initial) I authorize Focus-MD to access my prescription history (including dosage and refills) from the pharmacy database.

_____ (initial) I authorize Focus-MD to correspond with and/or release my medical records to my Primary Care Physician and Referring Provider

I have read and understand the above policies and procedures.

_____ _____

Parent/Guardian / Patient Signature (if pt is over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

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Financial Policy

This financial policy contains important information about payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to payment for services.

Please note: the party that brings the child to the office will be responsible for the visit's copay AND will also be the final responsible party on record. We will not be involved in parental court cases. Whoever brings the child to the office for a visit will be authorized to receive financial and medical information. Information regarding a visit will be available on the portal.

It is the patient's responsibility to make payment at the time of service for all services rendered if it is determined that the patient's insurance policy may not cover our services. You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. The contract with your insurance company mandates that we collect copays at this time. If a patient finds that they will be unable to pay in full upon check-out, they will be responsible for determining a payment plan agreed upon by Focus-MD *prior to the scheduled appointment*.

Additional Fees

No Show/Late Cancellation Extended Appointments	$100	Accommodation Requests	$15-$25
No Show/Late Cancellation Follow-Up Appointments	$30	Medical Records $5 search fee. $1/page up to 25 pages. $.50/page 26+ pages	
Returned Check/Declined Scheduled Card Payment	$35		

We require 24 advance notice for cancellations or reschedule. Less than 24 hours is considered "Late". As a courtesy, you may receive a reminder of your upcoming appointment by e-mail or text message. You are still responsible for honoring your appointment even if you do not receive a reminder. Unless other arrangements are made the parent or guardian of patients less than 18 years of age responsible for payment according to the terms described above.

Students, 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent / guardian or themselves. For those students whose parent / guardian(s) will maintain responsibility for payment, an authorization for services must be signed by that parent or guardian. As a convenience, the parent / guardian may provide a credit card number and authorize that the co-pay be billed to that card at each visit.

You, the patient, have a contract with your insurance carrier. Our services may or may not be covered by your particular policy. It is your responsibility to contact your carrier to determine if these are covered services under your contract ***prior*** to the date of service. A referral may be required by your insurance company for services to be paid. It is the ***patient's responsibility*** to obtain the required referral for treatment prior to the visit.

Our staff is happy to help with general questions relating to a claim or to provide additional information requested by your insurance carrier in order for the claim to be processed. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department by calling the number on the back of the card.

For each visit please bring:
Current insurance card and Driver's License
Co-pay/Deductible for the day's visit (this is an estimate from our billing dept.)
Cash, check, or credit card for paying any balance from previous billing.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

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Non-Covered Service Policy

As our patients, we want to provide you the best care possible. There may be certain services that we feel are necessary that are not covered by some insurance carriers.

- You will be expected to pay for those services in full at the time they are provided.
- Policy holders of insurance carriers other than those currently contracted with our Providers will be expected to pay in full at the time of service.

These procedures are frequently used by Focus-MD providers and may or may not be covered under your insurance policy.

New Patient Testing *(May or may not be covered under insurance)*	*Testing/Assessment* Codes
• QbTest / TOVA test	96132 & 96138
• CNSVS	96132, 96138, & 96139
• Clinicom	96132 & 96146
• Vanderbilt Assessment, NeuroPsych Questionnaire, Adult ADHD Self-Report Scale, ADHD Rating Scale IV	96127

I have read and understand that charges for services not covered by my insurance plan will be my responsibility to pay in full the day the services are rendered.

_____ _____

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

_____ _____

Date **Patient DOB:**

focusMD

Authorization for Release of Medical Information

Patients Name _____ DOB: _____ SSN:_____

Address: _____City _____State ____ Zip Code_____

Phone Number_____ Date of Request:_____

Focus-MD Birmingham
300 Office Park Drive Suite 303 Mountain Brook, AL 35223
Phone: 205-769-0649 Fax: 205-769-0657 eFax: 877-420-6670

☐ I authorize Focus-MD **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Focus-MD **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) ☐ Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Attorney/Legal ☐ Continued Care (Consult/Referral)

TYPE OF RECORDS REQUESTED (check one)

☐ Complete medical record

☐ Summary of records (Includes: Last well check, detailed summary of all visits, growth chart, allergies, and medication list)

☐ Office Notes

☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Testing Results ☐ Medication List ☐ Surveys/Assessments ☐ Office Notes

AUTHORIZATION VALID FOR: (Check one):

☐ This request only.

☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request and for medical records of any **future** treatment of the type described above until :_____(insert date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.

Signature of Patient or Representative_____Date_____

Relationship to Patient (If requester is not the patient) _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy: Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site. Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Focus-MD.* If you have questions and would like additional information, you may contact your office.

Focus-MD
Attn: Privacy Officer
3930-F Airport Blvd
Mobile, AL 36608

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

With my consent, Focus-MD, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Focus-MD, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be requested.

I have the right to request that Focus-MD restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Focus-MD, use and disclosure of my PHI to carry out TPO.

With my consent, Focus-MD may call, at the numbers provided, my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, billing information and any call pertaining to my clinical care, including laboratory results, treatment plans, condition updates among others. With my consent Focus-MD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Focus-MD may decline to provide treatment to me.

Patient Name: _____

Help Us Get to Know You

Please have the patient complete this questionnaire.

What do you do well?

What do you enjoy doing most?

How long have you been experiencing ADHD type symptoms?

Do you avoid talking on the phone?

Can you drink caffeine without it affecting your sleep?

Do you re-read paragraphs or pages because you didn't get it 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?

Are you frequently late for appointments?

Do you have significant time management problems? Is procrastination a problem for you?

Do you get frustrated and overwhelmed with school work, housework, your job, or other responsibilities?

Are you sensitive to noise, light, textures/touch?

Are you a worrier?

Do you feel unhappy a lot?

Do you have trouble making/keeping friends?

Patient Name: _____

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

Patient Name: _____

FAMILY HISTORY:

- Is your mother living? ☐ Yes, age: _____ ☐ No, age and cause of death: _____
- Is your father living? ☐ Yes, age: _____ ☐ No, age and cause of death: _____

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	Children	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:

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, who is your current ADHD care provider? _____
  - What are your reasons for changing ADHD providers? _____

Patient Name: _____

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

☐	Counseling	☐	Behavioral Modification	☐	Occupational Therapy
☐	Speech Therapy	☐	Reading Intervention	☐	Special Education

Do you have any history of the following? ☐ Yes ☐ No

☐	Learning Disorder	☐	Anxiety, Panic Attacks	☐	OCD
☐	Mood Disorder/Bipolar	☐	Depression	☐	Schizophrenia
☐	Tics/Tourette's	☐	Autism/Asperger's	☐	Substance Abuse/Addiction

Sleep History:

- Did you have a history of sleeping problems? ☐ Yes ☐ No
  - ☐ Trouble falling asleep ☐ Trouble staying asleep
  - ☐ Talking in sleep ☐ Frequent nightmares
  - ☐ Walking in sleep ☐ Vivid dreams

- Have you gone longer than 24 hours without sleep? ☐ Yes ☐ No
  If yes, were you tired the next day? ☐ Yes ☐ No If so, how often has this occurred? _____
  What is the maximum number of days you have gone without sleep? _____

- Do you feel tired during the day? ☐ Yes ☐ No

- Do you fall asleep during the day? ☐ Yes ☐ No

General Medical History:

Are you pregnant or nursing? ☐ Yes ☐ No

Do you have any history of the following? ☐ Yes ☐ No

☐	Hypertension	☐	High Cholesterol	☐	Heart Attack
☐	Heart Murmur	☐	Arrhythmia	☐	Seizure Activity
☐	Stroke	☐	Syncope/Fainting	☐	Thyroid Disease
☐	Diabetes	☐	Cancer	☐	Asthma
☐	COPD	☐	Head Injury Date: _____	☐	Cardiac Abnormality
☐	Migraine	☐	Headaches	☐	Reflux
☐	Allergies	☐	Arthritis	☐	Sleep Disordered Breathing
☐	Restless Leg Syndrome	☐	Other:		

☐	Normal Vision	☐	Vision Impaired	☐	Contacts	☐	Glasses
☐	Normal Hearing	☐	Hearing Impaired	☐	Hearing Aids	☐	Other:

SURGICAL HISTORY:

☐	Tonsillectomy	☐	Appendectomy	☐	Orthopedic Surgery
☐	Adenoidectomy	☐	Hysterectomy	☐	Gall Bladder Removed
☐	Tubes in ears	☐	Other:		

Patient Name: _____

SOCIAL HISTORY:

- What is your marital status?

  ☐ Married ☐ Never married ☐ Divorced
  ☐ Separated ☐ Widowed ☐ Partner

- With whom do you live?

  ☐ Alone ☐ Spouse/partner ☐ Spouse/partner and children
  ☐ Sibling ☐ Relatives ☐ Roommate/friend

- 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 ☐ Associate's Degree
  ☐ Bachelor's Degree ☐ Master's degree ☐ Doctorate or Law degree

- Are you currently in college? ☐ Yes ☐ No

  ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Grad School

- Do/did you have any of the following problems while in school?

  ☐ Attention problems ☐ Difficulty reading ☐ Poor school performance
  ☐ Discipline problems ☐ Difficulty w/math ☐ Work hard w/inferior results
  ☐ Under performance ☐ Turned in work late

- Did you have any academic support/accommodations while in school? ☐ Yes ☐ No

- Were you ever held back or failed a grade? ☐ Yes ☐ No Explain: _____

- What is your employment status?

  ☐ Full-time ☐ Part-time ☐ Per diem/contract
  ☐ Seasonal ☐ Retired ☐ Change jobs frequently
  ☐ Disabled ☐ Unemployed ☐ Problems with work performance

- What type of work do you do? _____

- Do you exercise regularly? ☐ Yes ☐ No

  ☐ Aerobic ☐ Weight lifting ☐ Flexibility ☐ Stability ☐ Strength training

- How would you classify your diet? ☐ Regular ☐ Vegetarian ☐ Other dietary restrictions_____

- List activities that you enjoy doing: _____

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

Patient Name: _____

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

  ☐ None ☐ Marriage ☐ Divorce
  ☐ Change in family dynamic ☐ Significant health diagnosis ☐ Financial problems
  ☐ Job Instability ☐ Job loss ☐ Loss of loved one
  ☐ Loss of relationship ☐ Relocation ☐ Academics/return to school
  ☐ Loss of loved one ☐ Loss of relationship ☐ Retirement
  ☐ Empty Nest ☐ New relationship

- What is your driving history?

  ☐ No moving traffic violations ☐ No accidents
  ☐ 2 or less moving traffic violations ☐ 2 or less accidents
  ☐ 3 or more moving traffic violations ☐ 3 or more accidents
  ☐ License suspended/revoked

- 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

  ☐ Several drinks daily ☐ Once a day ☐ A few days a week

  ☐ On weekends/socially ☐ Rarely ☐ Concern for addiction

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

  ☐ More than one pack a day ☐ Several daily ☐ A few days a week ☐ On weekends/socially

- Do you use marijuana? ☐ Yes ☐ No

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Have you used other drugs? ☐ Yes ☐ No

  ☐ Cocaine ☐ Xanax ☐ Narcotics ☐ Amphetamines ☐ Other

  ☐ Infrequent ☐ Frequent ☐ Concern for addiction

- Do you participate in any type of rehab program or substance abuse counseling? ☐ Yes ☐ No

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

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. 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?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B