



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 as follows:

Focus-MD Birmingham
300 Office Park Drive Suite 303
Mountain Brook, AL 35223
Ph: 205-769-0649
Fax: 205-769-0657
eFax: 877-420-6670
email: staff_bhm@focus-md.com



300 Office Park Drive Suite 303 Mountain Brook, AL 35223 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

Patient info:

Printed advertisement

Transfer from other FocusMD location

(Sex at birth required for neuropsychological testing per published diagnostic criteria.)

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:	

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 Policies

- ____ (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:



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
Returned Check/Declined Scheduled Card Payment	\$35	pages. \$.50/page 26+ pages	

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:



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.

<i>New Patient Testing</i> <i>(May or may not be covered under insurance)</i> <ul style="list-style-type: none">• QbTest/ TOVA test• CNSVS• Clinicom• EYSZ HV test• Vanderbilt Assessment, NeuroPsych Questionnaire, Adult ADHD Self-Report Scale, ADHD Rating Scale IV	<i>Testing/Assessment</i> <i>Codes</i> 96132 & 96138 96132, 96138, & 96139 96132 & 96146 96116 96127
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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:



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:

OR

☐ I authorize Focus-MD to obtain information from:

Name of Provider or Facility

Address

City, State, Zip Code

Phone Number

Fax Number

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) _____

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.

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?

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

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

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Duration</u>
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective			
Any side effects? <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe: _____			
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective			
Any side effects? <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe: _____			

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: ☐ None

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Duration</u>
	_____ mg _____ # tabs Time taken: _____ am/pm	<input type="checkbox"/> Almost if not every day <input type="checkbox"/> School/work days <input type="checkbox"/> Less than 5 days a week	<input type="checkbox"/> < 6 hours <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10-12 hours <input type="checkbox"/> Adequate <input type="checkbox"/> Not Adequate
Is this medication effective? <input type="checkbox"/> Not effective <input type="checkbox"/> Somewhat effective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective			
Any side effects? <input type="checkbox"/> No <input type="checkbox"/> 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: _____

- 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.) _____

FAMILY HISTORY:

Please indicate with a v 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						

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? _____

- 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

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Cardiac Abnormality	<input type="checkbox"/> Asthma/Allergies
<input type="checkbox"/> Enuresis (daytime accidents)	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Encopresis (soiling w/stool)
<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Frequent Ear Infections
<input type="checkbox"/> Seizures	<input type="checkbox"/> Reflux	<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> 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

- 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

<input type="checkbox"/> Resource classroom	<input type="checkbox"/> Individual testing
<input type="checkbox"/> IEP	<input type="checkbox"/> Reduced work volume
<input type="checkbox"/> 504 Plan accommodation	<input type="checkbox"/> Response to intervention
<input type="checkbox"/> Extended time on testing	<input type="checkbox"/> Informal accommodations
<input type="checkbox"/> Testing in a quiet environment	<input type="checkbox"/> 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?

<input type="checkbox"/> Sports/athletics	<input type="checkbox"/> Hunting/Fishing/Outdoors
<input type="checkbox"/> Music/Band	<input type="checkbox"/> Video Games _____ Hours per day
<input type="checkbox"/> Drama	<input type="checkbox"/> Social Media _____ Hours per day
<input type="checkbox"/> Martial arts	<input type="checkbox"/> TV/Other Media _____ Hours per day
<input type="checkbox"/> Art/Creative writing	<input type="checkbox"/> School Clubs/Social Clubs
<input type="checkbox"/> Electronic/Media time is a problem	_____ Hours per day total electronic time
- Describe the child's after school routine:

<input type="checkbox"/> Tutoring/Educational Intervention	<input type="checkbox"/> After school care
<input type="checkbox"/> Unstructured	<input type="checkbox"/> Car Rider
<input type="checkbox"/> Volunteer	<input type="checkbox"/> Rides Bus
<input type="checkbox"/> Homework is done after school	<input type="checkbox"/> Homework is delayed until evening

- How is the child's behavior at home?

- | | |
|--|---|
| <input type="checkbox"/> Good behavior | <input type="checkbox"/> Homework problems |
| <input type="checkbox"/> Problems with time management | <input type="checkbox"/> Oppositional behavior |
| <input type="checkbox"/> Problems with task completion | <input type="checkbox"/> Disrespectful behavior |
| <input type="checkbox"/> Meltdowns | |
- ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the child's relationships with family members?

- | | |
|---|--|
| <input type="checkbox"/> No unusual stress | <input type="checkbox"/> More than usual conflict with siblings |
| <input type="checkbox"/> Parent/child conflict | <input type="checkbox"/> Step-parent/child conflict |
| <input type="checkbox"/> Conflict with non-custodial parent | <input type="checkbox"/> Conflict with custodial parent/guardian |
| <input type="checkbox"/> Conflict with other family members | |
- ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the child's relationships with peers?

- | | |
|--|--|
| <input type="checkbox"/> Healthy, identifies friends | <input type="checkbox"/> Limited friendships |
| <input type="checkbox"/> Doesn't identify friends | <input type="checkbox"/> Some conflicts |
| <input type="checkbox"/> Significant conflict | <input type="checkbox"/> Problems making/keeping friends |
- ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any bullying issues?

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Child is teased/picked on |
| <input type="checkbox"/> Child bullies others | <input type="checkbox"/> Bullying is ongoing |
| <input type="checkbox"/> 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?

- | | |
|--|--|
| <input type="checkbox"/> Family conflict | <input type="checkbox"/> Absent parent |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Serious illness in the family |
| <input type="checkbox"/> School performance | <input type="checkbox"/> Death in the family |
| <input type="checkbox"/> Sibling relationships | <input type="checkbox"/> Natural disaster |
| <input type="checkbox"/> Financial stressors | <input type="checkbox"/> Loss of housing |
| <input type="checkbox"/> Substance abuse in home | <input type="checkbox"/> Other: _____ |

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

PLEASE RETURN TO :

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

focus_{MD}
Birmingham

FAX: 205-769-0657

eFAX: 877-420-6670

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Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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HE0351

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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