Adult Information Form

Today's Date:_____

Patient's Name _____Date of Birth ___

Your Name _____Relationship to Child _____

Please list the problems with which you want help:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Have you had previous evaluations?

___Yes ____NO

If so, where and when? Please do your best to obtain a copy of any evaluation you may have had.

_____
_____
_____

Have you received any special treatments outside of school? __Yes __No

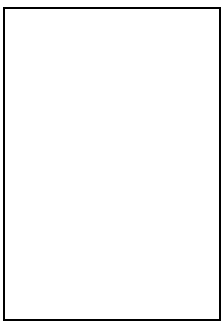
If so, please describe below:

Dates	**Types of Treatment (include name of any medicine)**

Any alternative treatments (including herbs, diets, biofeedback)??

Dates	**Types of Treatment (include name of any herb)**

Please attach a recent photograph.



Review Of Systems:

Any problems with any of the following:

Head: _____
Ears: _____
Eyes: _____
Throat: _____
Tonsils: _____
Heart : _____
Breathing :_____
Gastrointenstinal: _____
Genital Problems: _____
Bladder Problems: _____
Bone/Muscle: _____
Skin: _____
Neurological Problems: _____
Endocrine: _____
Blood: _____
Allergy/ Immune: _____

Current Medication:
_____
_____
_____

Family History:

Include Family History of Hyperactivity, Depression, Bipolar, Alcohol or Drug Use, Jail Time, School Problems, or other mental illness.
_____
_____
_____
_____
_____
_____
_____

Were you adopted? ____Yes _____No

Attention	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Does not pay attention to details				
Can not sustain attention when moderately motivated				
Does not seem to listen when spoken to				
Starts many projects that never get finished				
Difficulty with organization				
Avoids work that requires sustained mental effort				
Loses things necessary for task				
Easily distracted by extraneous stimuli				
Often forgetful in daily activities				

Hyperactivity	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Fidgets with hands, squirms in seat,				
Leaves seat in classroom				
Feels Restless				
Difficulty playing or engaging in leisure activities quietly				
Often “on the go”, Driven by a motor				
Talks excessively				

Impulsivity	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Saying things without thinking of the consequences				
Does things without thinking of the consequences				
Difficulty waiting turn				
Interrupts or intrudes on others (butts into conversation or games)				

Of the attention, hyperactivity and impulsivity signs and symptoms that applied, were most of them present before the age of seven? ___Yes ____NO

Tics	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Motor Tics				
Vocal Tics (makes grunting sounds)				
Tics many times a day for many days. No tic free period for more than three months.				
Tics cause social or school problems				

ODD	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Loses Temper				
Argues with Adults				
Often actively refuses to comply with adult requests or rules				
Often deliberately annoys people				
Blames others for his mistakes				
Touchy or easily annoyed				
Angry and resentful				
Spiteful or vindictive				

Sleep	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Trouble Falling Asleep				
Often Falls asleep during a Car Ride				
Snores Loudly/Trouble breathing when sleeps				
Often appears sleepy during the day				

Vision (ask child directly)	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Eyes tire easily when reading				
When reading do the words move/vibrate				
When reading do the words get blurry				
When reading is there color on the page or does the white part of the page encroach on the black				

Anxiety

	Definitely	Sometimes	Never
Appears anxious or worried			
irritable			
Has trouble sleeping, nightmares			
Bites nails, sucks thumb or sucks on hand or other habit			
Worried about health, wants to see the doctor often, says is ill			
Resists going to school, seeing new things , changing routines			
Has muscle aches			
Has lost a significant figure in the past due to death or disappearance.			
Has a specific fear?	What? _____		
Family history of anxiety, panic disorders, hypochondria.	Relation to patient _____		

Compulsions Obsessions

	Definitely	Sometimes	Rarely
Checking behaviors such as counting or hoarding			
Excessive hand washing			
Recurrent persistent intrusive thoughts, impulses, images			

Depression	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Decreased pleasure in almost all activities				
Feel like you have no energy				
Feel sad most of the time				
Insomnia or hypersomnia every day				

Other Comments: