ADULT ADHD FORM

PATIENT INFORMATION

Patient's Name: ____ SS# ______-______-______ Sex: ☐ Male ☐ Female

Date of Birth: _______________ Age: ______ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: ____

Home Phone: (________)_____________________________ Occupation: ____________________________________ ☐ Student

Employer (School, if student): ____________________________________ Work/School Phone: (________)_________________

Employer/School Address: ____

E-mail Address: ____ Fax Phone: (_________)_______________________

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: ____ Date of Birth: _____________

Home Address: ____

Home Phone: (_________)______________________________ Occupation: _______________________________________

Employer: ____ Work Phone: (___________)_____________________________

Employer Address: ____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: ____ Date of Birth: _________________

Spouse's Employer: __________________________________ Address: ____

Please complete this document as accurately as possible and remember all the information provided will be included in the final report which will be forwarded to you and the referring physician. There is a one time fee adults are required to pay at the first appointment. This fee will cover extensive psychometric tools used by the clinic to determine diagnosis and are not covered by the OHIP.

APPOINTMENT CANCELLATION POLICY: ADHD Clinic requires that cancellations for scheduled appointments be received 48 hours in advance during regular office hours (Monday through Friday 9am to 5:00pm. We will give you a courtesy call 24 hours prior to your visit. However we want you to understand that this is courtesy call only. It is not the clinics responsibility to remind you of your appointment. Missed or cancelled appointments that do not follow this policy will be charged the regular OHIP fee and the 120 dollar intake fee at the discretion of your doctor. This fee can be equal but will not exceed the OHIP Billing rate. OHIP does not pay for missed appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies of **ADHD Clinic.**

***Signature of Responsible Party* (required):** ____

Adult Intake Questionnaires

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

What is the main reason for this assessment? ☐ Not Sure ☐ Diagnosis ☐ Treatment ☐ 2nd Opinion
Please explain

What are the main concerns/problems at this time? ☐ Not Sure ☐ No concern or problem ☐ Other
Please explain

What is hoped to achieve, improve or change? ☐ Not Sure ☐ No goal ☐ Other
Please explain

What type of help is being sought?
☐ Medication ☐ Other
Please explain

Education
Name of School/Institution

Grade/Degree

Where

City

Province

School Services (Current or Previously)
☐ Special Education Class ☐ IEP (Individualized Education) ☐ Resource Period
☐ Educational Assistance ☐ Tutoring ☐ Other
Please explain

Condition Related to
☐ School ☐ Bullying ☐ Boyfriend / Girlfriend ☐ Friends ☐ Accidents ☐ Violence or Aggression
☐ Self-harm or Suicidality ☐ Drugs & Alcohol ☐ Parents & Family ☐ Relatives ☐ Abuse
☐ Legal Procedures

Please explain

Previous contact with Mental Health Professionals

Name of Agency(s) or Professional Reason(s) for contact (concern/diagnosis) Date and Duration Type of Treatment (Meds, Counseling)

Father Biological Step Adoptive Foster/Guardian

Name

Work/Occupation

Natural Father's History: age_____ outside work ____

School: highest grade completed ____

Learning problems __________________________ Behavior problems ______________________________

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc)____

____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? __________________

____

Father's alcohol/drug use history ____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____

____

Mother Biological Step Adoptive Foster/Guardian

Name

Work/Occupation

Natural Mother's History: age_____ outside work ____

School: highest grade completed ____

Learning problems __________________________ Behavior problems ______________________________

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc)____

____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _________________

____

Mother's alcohol/drug use history ____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____

____

Sibling 1 ☐ M ☐ F

Name

(age)

Sibling 2 ☐ M ☐ F

Name

(age)

Sibling 3 ☐ M ☐ F

Name

(age)

Sibling 4 ☐ M ☐ F

Name

(age)

Sibling 5 ☐ M ☐ F

Name

(age)

Sibling 6 ☐ M ☐ F

Name

(age)

Other Contacts

Family Physician
Name

Phone

Fax

Other Physician
Name

Phone

Fax

Therapist
Name

Phone

Fax

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)____

____

____

Prenatal and birth events: Your parents attitude toward their pregnancy with you ________________________
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc____
Any birth problems, trauma, forceps or complications?: ____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

____

____

Any work-related problems? ____
What would your employers or supervisors say about you? ____

Military History? ____

Ever Any Legal Problems? ____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: _______ Number of sexual partners: _________
Any history of sexually transmitted disease? _________ History of abortion? ____________________________
History of sexual abuse, molestation or rape? ____
Current sexual problems?____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. ____

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Ever experience withdrawal symptoms from alcohol or drugs? ____
Has anyone told you they thought you had a problem with drugs or alcohol? _____________________________
Have you ever felt guilty about your drug or alcohol use? ____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? __________________
Have you ever used drugs or alcohol first thing in the morning?____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) ___________________________________
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) ___________________

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

____

____

Current Marital or Relationship Satisfaction____

____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)____
____
____

History of Past Marriages ____

Children (names, ages, problems, strengths) ____
____
____

Cultural/Ethnic Background ____
____

Describe your relationships with friends ____
____

Describe yourself ____
____

Describe your strengths ____
____

	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 questions 1 to 18, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.			Never	Rarely	Sometimes	Often	Very Often
	Adult ADHD Self-Report Scale	(6/9, > 6m, >2 settings)	ADHD NOS					
	Part A							
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 B							
7	How often do you make careless mistake when you have to work on a boring 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 in other situations in which you are expected to stay 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 it themselves?							
17	How often do you have difficulty waiting your turn in situations when turn taking in required?							
18	How often do you interrupt others when they are busy?							

	Adjustment Disorder	Acute < 6m > chronic		Never	Rarely	Sometimes	Often	Very Often
	Recent stressor(s) within last 3 months causing marked distress							
	Dyssomnias							
	Primary Insomnia: Difficulty initiating or maintain sleep, or non-restorative sleep, for at least 1 month							
	Primary Hypersomnia: Excessive sleepiness for at least 1 month (prolonged sleep episodes or daytime sleep episode)							
	Narcolepsy: Irresistible attacks of refreshing sleep that occur daily over at least 3 months							
	Breathing-Related: Excessive sleepiness OR insomnia due to sleep-related breathing condition							
	Circadian Rhythm: Excessive sleepiness OR insomnia due to mismatch between sleep-wake schedule and circadian sleep-wake pattern							
	Parasomnias							
	Nightmare: Repeated awakenings with detailed recall of frightening dreams							
	Sleep Terror: Abrupt awakening from sleep, beginning with a panicky scream, unresponsive to comforting efforts of others							
	Sleepwalking: Rising from bed during sleep and walking about, with a blank, staring face, unresponsive to communicating efforts of others							
	Relational Problems							
	Parent-Child							
	Partner							
	Sibling							
	Abuse or Neglect							
	Physical	☐ As a child	☐ As an adult					
	Sexual	☐ As a child	☐ As an adult					
	Neglect	☐ As a child	☐ As an adult					
	Additional Conditions							
	☐ Bereavement	☐ Academic Problem	☐ Occupational Problem					
	☐ Identity Problem	☐ Religious/Spiritual Problem	☐ Phase of Life Problem					

PAST HISTORY

	No	Yes
Have you been treated for your present problem or any nervous or psychiatric condition?		
Have you ever been hospitalized for a psychiatric problem? If yes, please specify below.		

MEDICATIONS –PAST & CURRENT (Include ALL in order and approx. dates)

Name of Drug (i.e. Ritalin)	Dose of Tablet	# times /day	Time Taken (Br,Lun,Din,Bed)	Approx. Start & End Date (ie Jun 03-July 03)	Success: Worse or Better	Why Stopped? (ie loss of appetite)

CURRENT HEALTH

No	Yes

Medical Conditions (please mark all that apply):

☐ AIDS	☐ Blood pressure problems	☐ Heart attack	☐ Lung disease	☐ Seizures (epilepsy)
☐ Alcohol Dependency	☐ Cancer	☐ Heart murmur	☐ Lupus	☐ Shortness of breath
☐ Anemia	☐ Chemotherapy	☐ Heart problems	☐ Mitral valve prolapsed	☐ Steroid therapy
☐ Angina	☐ Chest pain	☐ Hepatitis	☐ Pacemaker	☐ Stomach ulcers
☐ Arthritis	☐ Cholesterol	☐ HIV infection	☐ Prosthetic heart valve	☐ Stroke
☐ Artificial / prosthetic joint	☐ Diabetes	☐ Jaundice	☐ Radiotherapy	☐ Thyroid disease
☐ Asthma	☐ Diet Medications	☐ Kidney disease	☐ Rheumatic fever	☐ Tuberculosis
☐ Bleeding problems	☐ Drug dependency	☐ Leukemia		☐ Visual impairments
	☐ Hearing impairments	☐ Liver disease		
Other	Other	Other	Other	Other

PAST HEALTH

1. MAJOR ILLNESSES/ HOSPITALIZATIONS/ SURGERIES

No	Yes

Age	Illness/Hospitalization/ Surgery (i.e. Tonsillectomy, Tubes inserted)	Treatment	Result

2. INJURIES/ACCIDENTS

No	Yes	
		Note also those related to drugs/alcohol/violence.

Year	Injury

3. PHYSICAL/SEXUAL ABUSE

No	Yes

Year	Include unreported injuries/untreated injuries (beatings/concussion/rape/abuse)	By spouse/partner/family member/other

FAMILY MEDICAL HISTORY

PATIENT HAS NO INFORMATION ON BIOLOGICAL: ☐ Mother ☐ Father ☐ Siblings

M=Mother; F=Father; S=Sister, B=Brother, MM=Mother's Mother; MF=Mother's Father FM=Father's Mother; FF=Father's Father				**Use Sib #**		**Mother's Side**			**Father's Side**						
	No Hx	M	F	S	B	Aunts	Uncles	Cousin	Aunts	Uncles	Cousin	MM	MF	FM	FF
ADHD/ADD															
Aggression/Violence/Abuse															
Alcohol Abuse															
Anxiety															
Bipolar Disorder															
Dementia (Early/Late)															
Depression															
Drug abuse															
Eating Disorders															
Imprisonment/Detention															
Learning Disabilities															
Mental Retardation															
Schizophrenia															
Suicide (Failed Attempts)															
Suicide (Successful Attempts)															
Any psychiatric hospitalization															
Family Medical History	No Hx	M	F	S	B	Aunts	Uncles	Cousins	Aunts	Uncles	Cousins	MM	MF	FM	FF
Asthma															
Cancer: lung, colorectal, breast															
prostate, cervical/uterine,															
pancreas, endocrine, other															
Diabetes Mellitus															
Heart Disease															
High Blood Pressure															
Irritable Bowel or Colitis															
Migraine Headaches															
Mitral Valve Prolapse															
Seizures (Epilepsy)															
Stroke															
Thyroid Disorder															
Ulcers															
Other:															
Age at Death															
Year of Death															
Cause of Death															
Unexpected Death															

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas

General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other______________________

Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other______________________

Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other________________________

Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other________________________ __

Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other______________________

Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other______________________

Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other________________________

Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other________________________

Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other______________________

Females
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other______________________

Males
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other______________________

Explanation

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