Office Use Only
VFC: [ ] V02 -- MDD [ ] V03 -- No Ins [ ] V04 -- Native [ ] V07 -- AVAP
INSURANCE:
Copay / Co-ins
Statement Balance

ADHD

Office Use Only
WT: _______kg ______lb
HT:_________O2: ______
Temp:________________
BP:_________Resp______
Pulse:________________
BMI_________________

Child's name: ______________________________ **Child's birthday:** ______________________

Who is your child's primary care physician? ______________________________

When was your child diagnosed with ADD/ADHD? ______________________________
Is your child taking medication for ADD/ADHD? Yes/no. What medication/dose? ______________________
How long has your child been at the current dose? ______________________________
Do you think the current dose is effective? Yes/no. explain ______________________________
What other medications has your child tried? ______________________________
Does the medication help with behavior at home? Yes/no. explain ______________________________
Does the medication help with behavior at school? Yes/no. explain ______________________________
Is there a time of day behavior is of more concern? Yes/no. explain ______________________________
Does your child have an IEP in place? Yes/no. explain ______________________________
Does your child have any learning disabilities? Yes/no. explain ______________________________
Parent/guardian comments ______________________________

Review of systems/medication side effects:

Headache	yes/no. If yes, how long?	______________
Chest pain	yes/no. If yes, how long?	______________
Decreased appetite	yes/no. If yes, how long?	______________
Vomiting	yes/no. If yes, how long?	______________
Abdominal pain	yes/no. If yes, how long?	______________
Rash	yes/no. If yes, how long?	______________
Joint pain	yes/no. If yes, how long?	______________
Involuntary muscle twitches (tics)	yes/no. If yes, how long?	______________
Emotional lability (mood swings)	yes/no. If yes, how long?	______________
Sleep problems	yes/no. If yes, how long?	______________

Does your child have a medication allergy? Yes/no. What medication/reaction? ______________________
Does your child have any chronic medical problems? Yes/no. If yes, please explain. ______________________
Is your child taking other daily prescribed medications? Yes/no. If yes, please explain. ______________________
Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. ______________________
Has your child had any surgeries? Yes/no. If yes, please explain. ______________________

Does anyone in the family have:

ADD/ADHD ?	Yes/no	please list: ______________________
Learning disabilities?	Yes/no	please list: ______________________
Mental illness (e.g. depression)	Yes/no	please list: ______________________

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? ______________________
Does your family have any pets? Yes/no. please circle: dog/cat/other ______________________
Are your child's immunizations up-to-date? Yes/no. If no, please explain. ______________________
Does your child attend daycare / preschool / school? (please circle) What grade in school? ______________
What school or daycare (or sitter) do they attend? ______________________
Does your child receive: counseling; speech, occupational or physical therapy? (please circle)

This form completed by: ______________________ **Relationship to Child:** ______________ **Today's Date**______________

Updated: 10/12/16