Medical History

Name: Date of Birth:

Address: Social Security Number:

Primary Care Provider: Phone Number:

Reason for visit today:

List any personal medical history:

Daily medications:

Allergies:

List any family medical history:

Have you been diagnosed with ADHD or ADHD-alike diseases by a medical professional before?

Were/are you on any ADHD-related medication (stimulant or non-stimulant) before or currently? If so, please specify the name of the medication, prescription instructions and when did you start the related medication?

Are you experiencing any of the following symptoms in the past three months? (Please choose all applied options.)

☐ Trouble focusing	☐ Can't finish tasks	☐ Disorganization
☐ Trouble multitasking	☐ Excessive activity or restlessness	☐ Depressed mood
☐ Unable to enjoy activities	☐ Sleep pattern disturbance	☐ Excessive guilt
☐ Excessive worry	☐ Fatigue	☐ Avoidance
☐ Hallucinations	☐ Suspiciousness	☐ Suicidal thoughts

Have you had bipolar, psychosis, schizophrenia, suicidal attempts or any mental hospitalization history in the past?

Any history of mental health conditions including ADHD in your family?

How long have you had the conditions about which you are consulting us?

☐ less than 6mos ☐ 6m-2y ☐ 2y-5y ☐ greater than 5yrs

How have your health problems progressed since they began?

☐ stable ☐ gradually improving ☐ rapidly improving ☐ fluctuating

☐ gradually worsening ☐ rapidly worsening

Please indicate the overall intensity of your symptoms:

☐ mild ☐ moderate ☐ severe ☐ very severe

What's your blood pressure and pulse rate in the past month?

Social History:

☐ smoking ☐ alcohol ☐ recreational drugs

☐ tea ☐ coffee ☐ sleeping pills ☐ laxatives/purgatives

Please list any medications you take:

What are the major stressors in your life?

Have you ever been diagnosed with the following?

☐ diabetes ☐ epilepsy ☐ heart condition ☐ cancer

☐ bleeding condition ☐ asthma ☐ HIV/AIDS ☐ thyroid condition

☐ liver disease ☐ irritable bowel ☐ rheumatoid arthritis ☐ kidney disease

☐ osteoporosis ☐ cardiovascular disease

☐ other:

Are you allergic to anything? (e.g.: foods, medications, pollens, chemicals, molds, animal hair, etc.)

Gd wmsp npmtgbcp ugjj npcqapg`c kcbga_rgml dmp wms* njc_qc jc_tc rfc l_kc*_bbpcqq_lb nfmlc md rfc nf_pk_aw wms ugjj ngai gr sn8