211 E. Butler Rd., Suite C1
Mauldin, SC 29662
P: 864-305-1662
F: 864-603-2067
E: frontdesk@greenvilleadhd.com
www.GreenvilleADHD.com

Patient Registration Packet

Thank you for choosing Greenville ADHD Specialists! We are happy to have your child as a patient and are committed to providing the best possible care. Please follow the directions below.

Directions for completing paperwork:

1. Please complete all paperwork in its entirety. It is important for us to obtain a complete medical history. If completing online, you cannot save and come back to finish later. There is one section where your child will have to answer questions themselves.

2. The following records are also needed, **if applicable**. We are happy to obtain medical records for you, just complete the enclosed Release of Information Form.

   Records needed from past 3 months: Report cards or Teacher Notes

   Records needed from past 12 months:

   - ☐ Pediatrician (including lab results)
   - ☐ Therapy notes
   - ☐ IEP or 504 Plans
   - ☐ Standardized testing

   Records/Results done at any time:

   - ☐ Educational and Psychological screening assessments
   - ☐ IQ testing

   Court related documents:

   - ☐ Custody
   - ☐ Adoption
   - ☐ Foster Care

3. Please read each section carefully, especially our business policies. We want to be sure you understand our policies and charges. Please don't hesitate to ask questions.

4. Return your completed paperwork as soon as possible to start the review process. If completing from our online link, it will be automatically submitted when you click DONE. If manually completed, you may scan and email to us: frontdesk@greenvilleadhd.com or drop it by our office during business hours at the address listed above.

5. Once the provider has reviewed and accepted, we will contact you to schedule. This process takes 1-2 weeks.

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New patient evaluations are split into 2 separate appointments- testing and meeting the Provider.

On the day of TESTING: typically takes 45-60 minutes

1. **No caffeine (or nicotine if applicable) for the patient at least 2 hours prior** to appointment for accurate testing results.
2. If your child is currently prescribed medication for ADHD, please **do not give medication** the day of testing.
3. Bring your insurance card(s), pharmacy card, and photo ID with you. We will also take a patient photo for the chart.
4. Bring a list of all current medications and supplements with dosage, or the original bottles.
5. **Payment of $200 is required** on the day of testing.

On the day of your child's new patient appointment: typically takes 60-90 minutes

1. Payment is due at the time of service. Cost is $500 (payment plans available, minimum $200 due day of) or **$400 if paid-in-full**.
2. It's very helpful to have both parents (or all adults who are primary caregivers) present at this appointment.
3. We also suggest using a voice recording device or app on your phone to record your conversation with the provider. It can be very helpful to go back and listen, as you will be receiving a lot of information.
4. The time needed for your child's first appointment is about 1-1.5 hours, so plan accordingly.

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Patient Information

All information disclosed is strictly confidential and will become part of your medical record. Please print clearly, sign and date the bottom.

Patient Legal Name:		**Preferred Name:**
Gender: ☐ Male ☐ Female	**Date of Birth:**	**Social Security Number:**
Name of School:		**Current Grade Level:**
1st Parent/Legal Guardian:		**Relationship to Patient:**
Mailing Address:		**Zip Code:**
Phone #: ☐ Home ☐ Cell ☐ Work		**Email:**
Please select your preferred method of contact for **automated appointment reminders**: ☐ Email ☐ Text **Please remember: DO NOT REPLY to automated appointment reminders, you MUST CALL/TEXT THE OFFICE to change or cancel your appointment.		
2nd Parent/Legal Guardian:		**Relationship to Patient:**
Mailing Address:		**Zip Code:**
Phone #: ☐ Home ☐ Cell ☐ Work		**Email:**

EMERGENCY CONTACT	
Name:	**Relationship to Patient:**
Phone #:	**Email:**

FINANCIAL GUARANTOR		
Who is financially responsible for account? ☐ Self (patient) ☐ Other If Other, please complete guarantor information.		
Name:		DOB:
Relationship to Patient:	Social Security Number:	
Phone #:	Email:	
Mailing Address:		**Zip Code:**

ELECTRONIC COMMUNICATION CONSENT

I agree that Greenville ADHD Specialists may communicate with me electronically using the information I have provided above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am aware that standard text message charges from my cell phone provider may apply. I am aware that electronic communications may be printed or transcribed in full and made part of my medical record.

I understand that it is my responsibility to keep the practice up to date with my contact information. I may change or withdraw my consent to text/email communications anytime by calling 864-305-1662. I accept all risks and authorize the following means of communication by marking the box below:

☐ Text / Email
☐ Text ONLY
☐ Email ONLY

PRIMARY CARE PHYSICIAN		
Doctor's Name:		**Practice:**
Phone:	**Fax:**	**Address:**

REFERRAL SOURCE

☐ INTERNET/WEBSITE ☐ PHYSICIAN ☐ THERAPIST ☐ SCHOOL ☐ FAMILY ☐ FRIEND ☐ OTHER:

REFERRING PROVIDER		
Name:		**Practice:**
Phone:	**Fax:**	**Address:**

Signature: _____ **Date:** _____

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that if I want to receive treatment from Greenville ADHD Specialists, P.A. ("the Practice"), I must give consent for them to use and disclose protected health information ("PHI") among themselves and with other individuals for treatment, payment and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

I understand that the Practice has a Notice of Privacy Practices ("Notice") that describes in detail (1) how my PHI is used and disclosed, (2) when I need to give further approval for the Practice to use and disclose my PHI, (3) when my permission is not needed for the Practice to use and disclose my PHI, (4) my rights regarding my PHI, and (5) grievance procedures if I believe my privacy rights have been violated.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that Greenville ADHD Specialists, P.A. reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (864) 305-1662.

By signing below, **I agree that Greenville ADHD Specialists, P.A. may**:

1. Use my PHI, on a need to know basis, to give me treatment.
2. Disclose my PHI and correspond with others who are involved with my care either in or outside of the Practice. Including, but not limited to: referring providers, primary care physicians, other healthcare providers, therapists, counselors, teachers or school representatives.
3. Use my PHI for billing purposes.
4. Disclose my PHI with health insurance companies, government agencies, or other payers that request information related to benefits, claims filed, and other billing matters.
5. Disclose my PHI with outside parties who contract with the practice to perform services on behalf of our patients. (ie: Qb Tech, CNS Vital Signs, Lab companies)
6. Use my PHI to obtain my medication history from the pharmacy database.
7. Disclose my PHI and communicate confidential information (ie: appointment and medication/prescription information, invoices for services) to the address, email, and phone number(s) provided and leave a message on voicemail or with someone who answers if I am not available.

I understand that I may request restrictions on the uses and disclosures of my PHI. The Practice is not legally required to accept my request, but if it does, it is bound by this agreement and will abide by the restrictions except in emergency situations, or where required by law.

I understand that I may revoke this consent, in writing, at any time except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I also understand that if I revoke this consent, the Practice has the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my protected health information as described above.

Signature: _____ Date: _____

PRINT Name: _____

Relationship to Patient: _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The privacy of medical information is important. We will only discuss information with the person(s) designated.
The following person(s) may receive information:

Name: _____ Relationship: _____ Contact Number: _____

Please check all that apply:

☐ Billing/Insurance ☐ Appointment Information ☐ Medical Information (medications, test/lab results)
☐ All of the above

Name: _____ Relationship: _____ Contact Number: _____

Please check all that apply:

☐ Billing/Insurance ☐ Appointment Information ☐ Medical Information (medications, test/lab results)
☐ All of the above

Name: _____ Relationship: _____ Contact Number: _____

Please check all that apply:

☐ Billing/Insurance ☐ Appointment Information ☐ Medical Information (medications, test/lab results)
☐ All of the above

Note: This designation does not give the above named individuals the right to make health care decisions for you. Patients 18 and over, it is YOUR responsibility to contact our office with any medication questions or concerns.

The following person(s) listed below **DO NOT** have permission to receive any information regarding my medical treatment or any account information:

Note: For minors, if a parent is listed to not receive any information, we require court documentation on file to honor this request.

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I understand that I may revoke this consent, in writing, at any time except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

Signature: _____ Date: _____

PRINT Name: _____

Relationship to Patient: _____

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NOTICE OF PRIVACY PRACTICES

Effective April 1, 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Protected health information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access 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, and to notify affected individuals following a breach of unsecured protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, calling the office to request that a revised copy be sent to you by mail or email, or asking for one at the time of your next appointment.

How we may use and disclose your PHI:

· **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. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who referred you to us, or will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

Your authorization is required to disclose PHI to any other provider not currently involved in your care.

· **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 other business activities.

We will share your PHI with third party "business associates" that perform services (for example, billing or testing services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we have a written contract that contains terms to protect the confidentiality and security of your PHI.

We may use and disclose PHI to contact you with appointment reminders or prescription information by phone or email. If you are not home, we may leave this information on your voicemail or with the person answering the phone. We may also use and disclose PHI by having you sign a sheet for prescription pick-up. At an appointment, we may call out your name when we are ready to see you.

· **Required by Law**: As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, 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 notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

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Your PHI Rights:

To exercise any of these rights, please submit your request in writing to our Practice at the address listed above:

· **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. This means you may inspect and obtain a copy of your PHI for so long as we maintain the PHI. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

· **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. 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.) We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

· **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you have a right to request that we amend the information. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. However, we are not required to agree to the amendment or change your information.

· **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

· **Right to Receive Notification in the Event of a Breach.** You have a right to receive notification if there is a breach of your PHI. After learning of a breach, we must provide notice to you without unreasonable delay and in no event later than 60 calendar days after discovery of the breach, unless a law enforcement official requires us to delay the breach notification

· **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.

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 the information.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Greenville ADHD Specialists at the address listed above. If you have questions and would like additional information, you may contact our office.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signature: _____ Date: _____

PRINT Name: _____

Relationship to Patient: _____

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BUSINESS POLICIES

Please read each section carefully and initial each paragraph acknowledging that you understand.

Appointment Policy

We value the time we have set aside to see and treat you. Please help us serve you better by **keeping scheduled appointments**. If you are unable to keep your scheduled appointment, please let us know. This will give us the opportunity to offer that time to another patient.

_____ 1. We **require at least a 24-hour notice** if you need to reschedule or cancel your appointment to avoid any fees.

- **No Show- New Patient Appointment** **$200**
- **Late Cancellation Fee- New Patient Appointment** **$100**
- **No Show- Follow Up Appointment** **$100**
- **Late Cancellation Fee- Follow Up Appointment** **$50**

_____ 2. You must CALL OR TEXT THE OFFICE at 864-305-1662 to cancel or reschedule your appointment. **Do not reply to automated appointment reminders.** No messages from the office number, 864-305-1662, are automated. Please add this number to your phone.

_____ 3. Multiple missed or cancelled appointments may result in dismissal from the practice. Monday appointments must be cancelled by the previous business day, during business hours (typically Friday between 8 am – noon, unless Friday is a holiday). The same applies to Tuesday appointments when Monday is a holiday.

_____ 4. As a courtesy we will notify you by text or email of your upcoming appointment. However, **we do not guarantee notification** and may not be able to notify you 24 hours in advance. You are responsible for keeping track of your appointment date and time.

_____ 5. **If you are late** for your appointment, we will do our best to accommodate you. However, on certain days it may decrease your time with the provider or be necessary to reschedule your appointment and the **cancellation fee applies**.

_____ 6. If the patient is under 18 years old, they must be accompanied by their parent or legal guardian at every visit. If you wish for your child to attend an appointment alone or with someone else, **we must have a signed consent on file prior to appointments**. Please ask us for this form if needed.

Financial Policy

Greenville ADHD Specialists is **private pay and no claims will be filed to insurance.**

_____ 1. **Payment in full is required at the time of service**. We accept cash, check, credit/debit card, and HSA/flexible spending account cards.

_____ 2. If special circumstances make immediate payment in full impossible, payment arrangements must be approved and agreed upon by Greenville ADHD Specialists **prior to receiving services**. There is a **$25.00 non-payment fee** if payment is not made at time of service, and a payment arrangement has not been approved prior to visit.

_____ 3. Any patient balances are **due within 30 days** of receipt of your bill.

_____ 4. **Overdue balances**, including family accounts, must be paid prior to or on the day of your next appointment, and/or before a prescription may be sent in.

_____ 5. Bills unpaid for more than 90 days may be **turned over to a collection agency** unless other arrangements have been made. An additional 25% processing fee will be added to the balance and will result in dismissal from the practice.

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_____ 6. **Office Fees and Charges:**

• **New Patient Testing**	**$250**
• **New Patient Appointment**	**$500**
• **Follow-up Appointments**	**$150 - $350**
• **Qb Test 2** (discounts apply to retests)	**$225**
• **CNS Vital Signs Test**	**$150**
• **Drug Screens**	**$30**
• **Accommodation & Form Requests**	**$15 - $50**
• **Patient Records** (print or electronic)	**$30** (first 30 pages)
• **Prescription Fee**	**$20** (per medication)
• **Mailing Fee**	**$15**
• **Failed Credit Card Transaction**	**$10**
• **Returned Check**	**$35**
• **Non-Payment Fee**	**$25** (payment not made on service date, or if arrangement fails.)

Prescription Policy

_____ 1. Patients must be seen at least **every 3 months** to receive prescriptions for controlled substances.

_____ 2. For prescription requests, please contact us **2-3 days prior to running out of your medication**. It may take up to 48 hours to complete your request.

_____ 3. Prescriptions requested between appointments are subject to a **$20 fee** depending on circumstances. Request prescriptions during regular business hours. We do not send after hours or on weekends.

_____ 4. If prescriptions are not filled on time and expire at the pharmacy, there is a **$20 prescription replacement fee**. In SC, controlled substance prescriptions expire 90 days from the date written.

_____ 5. All outstanding **balances must be paid in full** before a prescription can be sent to the pharmacy unless a payment arrangement is already in place.

_____ 6. If a patient **NO SHOWS** (miss a scheduled appointment without prior notification), there will be no more prescriptions until the patient is seen for an appointment.

_____ 7. If there is any type of abuse or misuse of medication, you will be discharged from the practice immediately. **You must obtain ADHD medication from Greenville ADHD Specialists only**. We check the DHEC database for compliance. ADHD medication prescribed from another provider while under our care is grounds for immediate discharge.

_____ 8. **Random drug screens may be performed** at the discretion of the provider. The fee for these screens is nonrefundable, and the responsibility of the patient.

By signing below, I acknowledge that I have read and understand these business policies and agree to comply and accept responsibility as outlined above. I understand that this is a legal and binding document.

Signature: _____ Date: _____

PRINT Name: _____

Relationship to Patient: _____

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NEW PATIENT INTAKE FORM: CHILD & ADOLESCENT

Patient Name: _____

Date of Birth: _____

Name of person completing form:		Relationship to patient:	
Date completed:			

1. **What are your main concerns regarding the patient?** For example, inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behaviors, etc. Please describe.

2. Has the patient ever been formally diagnosed with ADHD?	☐ Yes	☐ No
If yes, when were they diagnosed?	And by whom?	
Do you have documentation of the diagnosis?	☐ Yes	☐ No
Are they currently under a provider's care for ADHD?	☐ Yes	☐ No
Are they currently taking medication for ADHD?	☐ Yes	☐ No

3. **When do you think the problems with ADHD started?**		
4. Can they sit still?		☐ Yes ☐ No
5. Do they only hear part of directions?		☐ Yes ☐ No
6. Do they put their own safety at risk?		☐ Yes ☐ No
7. Do they get easily distracted?		☐ Yes ☐ No
8. Do they have difficulty completing tasks?		☐ Yes ☐ No
9. Do they lose things necessary for tasks?		☐ Yes ☐ No
10. Are they organized at home?		☐ Yes ☐ No
11. Are they organized at school?		☐ Yes ☐ No
12. Are they sensitive to:	Noises?	☐ Yes ☐ No
	Light?	☐ Yes ☐ No
	Textures?	☐ Yes ☐ No
	Touch?	☐ Yes ☐ No

Does the patient have any medication allergies? ☐ **Yes** ☐ **No** If yes, please list below.	
Name of Medication	Describe the Reaction

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List all CURRENT medications including over-the-counter, such as allergy meds, vitamins/supplements	
Initial if no prescribed medication or supplements/vitamins are taken _____	
Name of Medication and Strength	Frequency Taken

List any <u>past</u> ADHD medication trials	
Name of Medication and Strength	Dates Tried, Benefits and/or Side Effects

CURRENT PHARMACY INFORMATION			
	Name	Address – Street name is fine for local address	Phone
Local			
Mail Order			

LIST MEDICAL PROVIDERS- CURRENT/PAST (LAST 5 YEARS)		
Provider Name	Practice Name	Specialty

SURGICAL HISTORY			
Hospitalizations	☐ Yes	☐ No	Dates/Reasons:
Tonsillectomy	☐ Yes	☐ No	Age:
Adenoidectomy	☐ Yes	☐ No	Age:
PE Tubes	☐ Yes	☐ No	Age(s):
Other Surgeries	☐ Yes	☐ No	Dates/Description:

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MEDICAL HISTORY								
Concussion	☐ Yes	☐ No	Description:					
Loss of consciousness	☐ Yes	☐ No	Description:					
Frequent Headaches	☐ Yes	☐ No	Frequent heartburn	☐ Yes	☐ No			
Seizures	☐ Yes	☐ No	Only with fever?	☐ Yes	☐ No			
Vision Problems	☐ Yes	☐ No	Glasses/Contacts	☐ Yes	☐ No			
Ear Infections	☐ Yes	☐ No	Hearing Test	☐ Yes	☐ No	Abnormal?	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Seasonal Allergies	☐ Yes	☐ No			
Anemia	☐ Yes	☐ No	Elevated Lead Level	☐ Yes	☐ No			
Thyroid Problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No			
Heart Murmur	☐ Yes	☐ No	Cardiac Abnormalities	☐ Yes	☐ No			
Elevated Blood Pressure	☐ Yes	☐ No	Elevated Lipids	☐ Yes	☐ No			
Frequent Constipation	☐ Yes	☐ No	Chronic Diarrhea	☐ Yes	☐ No			
Bedwetting	☐ Yes	☐ No	Age Potty Trained:					
Broken Bones	☐ Yes	☐ No	Description:					
Does your child have any other medical diagnoses not listed above or below?								

MENTAL HEALTH HISTORY							
Has the patient ever been diagnosed with any of the following? If yes, please describe treatments or medications tried.							
Anxiety / OCD / Panic	☐ Yes	☐ No					
Depression	☐ Yes	☐ No					
Bipolar Disorder	☐ Yes	☐ No					
Schizophrenia	☐ Yes	☐ No					
Autism Spectrum Disorder	☐ Yes	☐ No					
ODD- Oppositional Defiant Disorder	☐ Yes	☐ No					
Vocal Tics	☐ Yes	☐ No					
Motor Tics	☐ Yes	☐ No					
Self-Injury or Cutting	☐ Yes	☐ No					
Other Psychiatric Disorder	☐ Yes	☐ No					
Have you ever worked with an ADHD coach?	☐ Yes	☐ No	When:	Who:			
Counseling/Therapy	☐ Yes	☐ No	Last visit:	Therapist:			
Any hospitalizations for mental health illness?	☐ Yes	☐ No	Dates:				
Reason:			Place:				

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BIRTH HISTORY		
Any pregnancy complications?	☐ Yes ☐ No	If yes, please explain:
Length of Pregnancy	☐ Term ☐ Premature ☐ Overdue	Weeks:
Type of Delivery	☐ C-section ☐ Vaginal ☐ Induced ☐ Emergency C-section	
Any delivery complications?	☐ Yes ☐ No	If yes, please explain:
Any postnatal complications?	☐ Yes ☐ No	If yes, please explain:
	☐ NICU Hospitalization ☐ Required Oxygen ☐ Seizures ☐ Jaundice	
Birth Weight		

DEVELOPMENTAL HISTORY			
Any developmental delays (compared to others at the same age)? ☐ Yes ☐ No			
Speech	(single words, sentences) ☐ Early ☐ Average ☐ Late		
	Speech Therapy ☐ Yes ☐ No	Age of First Therapy:	Age of Last Therapy:
Motor Skills	(sitting up, walking) ☐ Early ☐ Average ☐ Late		
	Physical Therapy ☐ Yes ☐ No	Age of First Therapy:	Age of Last Therapy:
Fine Motor	(stacking blocks, drawing circle) ☐ Early ☐ Average ☐ Late		
	Occupational Therapy ☐ Yes ☐ No	Age of First Therapy:	Age of Last Therapy:

SCHOOL HISTORY					
Where does the patient attend school?					
Grade Level:	Typical Grades:				
Academic Strengths:		Academic Weaknesses:			
How are/were grades in:	Elementary school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	Middle school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	High school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
How difficult is homework/studying?					
Behavior/Discipline Problems in School ☐ Yes ☐ No		Please describe:			
Has the patient ever received IQ or Academic testing for learning problems?				☐ Yes	☐ No
If yes, when was testing?		Who performed testing?			
Learning Problems	☐ Yes ☐ No	If yes:	☐ Reading	☐ Writing	☐ Math
	Testing ☐ Yes ☐ No	Date:		Performed by:	
**** Please bring copy of testing, 504 Plan, and/or IEP meetings/plans***					
School Suspensions ☐ Yes ☐ No	When/Why:				
Does the patient participate in any of the following:					
Resource Class? ☐ Yes ☐ No	Which subjects, how many hours?				
Accelerated or Honors Courses? ☐ Yes ☐ No	Which subjects?				
IEP (Individual Education Plan)? ☐ Yes ☐ No	Last meeting?				
504 Plan? ☐ Yes ☐ No	Last meeting?				

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SOCIAL HISTORY						
Is the patient your biological child? ☐ Yes ☐ No					If adopted, age at adoption?	
Has the child ever been the victim of trauma? ☐ Yes ☐ No						
Has the child ever been the victim of abuse? ☐ Yes ☐ No						
Has the child ever been the victim of neglect? ☐ Yes ☐ No						
Has the child ever been the victim of sexual abuse? ☐ Yes ☐ No						
Has the child ever been the victim of emotional abuse? ☐ Yes ☐ No						
Parent Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Domestic Partner
Whom does the child live with?						
Is custody shared? ☐ Yes ☐ No If yes, answer the following question.						
How often does the child change houses?						

List any after school or extracurricular activities:					
Exercise Habits	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)				
	☐ Occasional vigorous exercise (i.e., sports or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., sports or recreation 4x/week for 30 minutes)				
Dietary Habits	☐ Normal	☐ Excessive Eating	☐ Poor Appetite	☐ Craves Sugar	
Caffeine Intake	☐ None	☐ Coffee	☐ Tea	☐ Cola	☐ Energy Drinks
	#cups/cans per day:	#:	#:	#:	#:

SLEEP HISTORY			
Problems Falling Asleep	☐ Yes	☐ No	
Problems Staying Asleep	☐ Yes	☐ No	
Snoring	☐ Yes	☐ No	
Sleep Walking	☐ Yes	☐ No	
Sleep Talking	☐ Yes	☐ No	
Restless Legs	☐ Yes	☐ No	
Difficulty waking up in AM	☐ Yes	☐ No	
Night Terrors	☐ Yes	☐ No	
Nightmares	☐ Yes	☐ No	
Sleep Study	☐ Yes	☐ No	Date/Results:

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FAMILY MEDICAL HISTORY	
Check the box next to any medical condition below that has affected any of the patient's immediate family members (parents, brothers, sisters) and state their relationship.	
Initial if none _____	Relationship
☐ ADHD	
☐ Anxiety	
☐ Depression	
☐ Panic Disorder	
☐ Bipolar Disorder	
☐ OCD- Obsessive Compulsive Disorder	
☐ Schizophrenia	
☐ Substance Abuse/Addiction or Alcoholism	
☐ Learning Disabilities	
☐ Autism, Asperger's, Pervasive Developmental Disorder	
☐ Tic Disorder	
☐ Seizures	
☐ Migraines	
☐ Allergies	
☐ Asthma	
☐ Thyroid Disease	
☐ High Blood Pressure	
☐ High Cholesterol/Lipids	
☐ Diabetes	
☐ Heart Disease	
☐ Sudden Cardiac Death	
☐ TIA/Stroke	
☐ Cancer- type:	
☐ Other:	

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SOCIAL SKILLS CHECKLIST

Patient Name:	**Date of Birth:**
Parent's Name:	**Date:**
School:	**Grade:**

This information is useful in gaining a complete understanding of your child's strengths and deficits.

Do any of the following apply to your child:			
1	Has difficulty with eye contact	☐ Yes	☐ No
2	Intimidates playmates	☐ Yes	☐ No
3	Interrupts conversations; doesn't wait turn	☐ Yes	☐ No
4	Has a hard time meeting and making friends	☐ Yes	☐ No
5	Quick to anger over insignificant issues; at times may react aggressively	☐ Yes	☐ No
6	Relates better to adults and much older children than to peers	☐ Yes	☐ No
7	Overly concerned that other children obey the rules	☐ Yes	☐ No
8	Overly competitive to the detriment of friendships	☐ Yes	☐ No
9	Is usually singled out to be picked on; easy target for bullying	☐ Yes	☐ No
10	Teases and puts others down; uses name calling, malicious and negative remarks	☐ Yes	☐ No
11	Has poor manners	☐ Yes	☐ No
12	Prefers to be alone rather than with friends	☐ Yes	☐ No
13	Frequently loses emotional control in front of others	☐ Yes	☐ No
14	Doesn't like to cooperate; feels more comfortable working alone	☐ Yes	☐ No
15	Always thinks his/her idea is the best and doesn't consider anyone else's ideas	☐ Yes	☐ No
16	Often acts frightened and helpless due to bullying	☐ Yes	☐ No
17	Bullies others	☐ Yes	☐ No
18	Frequently boasts or brags	☐ Yes	☐ No
19	Has low self-esteem	☐ Yes	☐ No
20	Rarely takes responsibility for mistakes; always someone else's fault	☐ Yes	☐ No
21	Speaks and acts like an adult, does not speak like children his/her age	☐ Yes	☐ No
22	Has difficulty letting friends have their way; always wants his/her way	☐ Yes	☐ No
23	Always angling to win, switches rules in the middle of the game	☐ Yes	☐ No
24	Has trouble starting and sustaining normal conversation with other children	☐ Yes	☐ No
25	Frequently acts in selfish manner; self-centered	☐ Yes	☐ No

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26	Won't let other people talk; tends to monopolize conversations	☐ Yes	☐ No
27	Difficulty joining in play with peer groups	☐ Yes	☐ No
28	Unaware of how his/her anger outbursts contribute to problems with peers	☐ Yes	☐ No
29	Refuses to engage in an activity in which he/she doesn't excel	☐ Yes	☐ No
30	Argues with adults and others in authority	☐ Yes	☐ No
31	Acts like a poor loser	☐ Yes	☐ No
32	Unassertive- lets other take advantage of him/her	☐ Yes	☐ No
33	Doesn't apologize or make amends	☐ Yes	☐ No
34	Frequently uses inappropriate volume or vocal tone	☐ Yes	☐ No
35	Doesn't seem to understand peer's reactions to their irritating behavior	☐ Yes	☐ No
36	Impulsive; charges ahead without thinking	☐ Yes	☐ No
37	Doesn't share or take turns	☐ Yes	☐ No
38	Often gets in other's personal space	☐ Yes	☐ No
39	Often acts in a very silly manner just to get peer's attention	☐ Yes	☐ No
40	Exhibits socially unacceptable behaviors	☐ Yes	☐ No
41	Difficulty with picking up nonverbal social cues	☐ Yes	☐ No
42	Quits game before it is over	☐ Yes	☐ No
43	Other (please specify):	☐ Yes	☐ No
44	Other (please specify):	☐ Yes	☐ No
45	Other (please specify):	☐ Yes	☐ No

Using items from the above list, please pick and rank the top five problems your child is having socially (1 being the most important).	
1	
2	
3	
4	
5	

Have any of the five identified deficits improved or worsened lately? If so, how?

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List any positive social skills your child has or any other relevant information that would be helpful to know.

What is your desired outcome for your child?

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QUESTIONS FOR THE PATIENT

Name:	**Date:**
School:	**Grade:**

Please have the PATIENT answer these questions. If they are too young to write the answers themselves, please ask the questions and write their response for the answer.

What are you good at doing?

What do you enjoy doing?

What is your favorite thing about school?

What is your least favorite thing about school?

Is it hard to sit still in class?

Does your teacher think you talk too much?

Is it hard to pay attention to the teacher?

Is it hard to wait your turn? Think about when you have to wait in line, or if you want to give an answer; is that hard for you?

Do you have a good friend at school?

Is it hard to keep up with things like pencils, books, jackets or sports equipment?

Is homework hard to finish?

Do you or your parent ever yell or cry over doing homework?

Do you worry a lot?

Are you sad a lot?

School Name _____

Grade Level _____

SCHOOL CONTACT INFORMATION FOR ASSESSMENTS

Please provide information for your child's core subject teacher(s), for example: English, Math, and Science/Social Studies. Assessments are sent via email to request feedback and insight from your child's teacher(s) which is beneficial to our providers. **These assessments are important to receive prior to your child's appointment.**

**In the summer, we ask for information from a tutor, babysitter/nanny, summer camp leader, day care teacher, Sunday school teacher, etc. (Adult non-family member who is frequently involved with your child).*

Patient Name _____ DOB _____

Teacher Name	Subject	Period	Email Address

RELEASE OF INFORMATION

By signing this agreement, I authorize my Provider to communicate with individuals listed above to gather behavioral and academic performance information. I understand this information is to be used for evaluation and treatment purposes.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

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AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete this form in order for Greenville ADHD Specialists to obtain information from or release to another provider (i.e. primary care physician, therapist, counselor, school, testing center, etc.).

Patient Name: _____ **Date of Birth:** _____

Previous Name (if used in records): _____ SSN (last four digits) _____

I authorize Greenville ADHD Specialists to **RECEIVE my information FROM and/or RELEASE my information TO** the following person or organization.

Name of Individual/Organization:			
Address:	City:	State:	Zip:
Phone:	Fax:		

INFORMATION TO BE RELEASED (Please check all that apply for the person or organization listed above):

Healthcare / Clinical:

- ☐ Encounter Notes (Past 12 months or last visit)
- ☐ Lab Reports
- ☐ Sleep Study Results & Notes
- ☐ Well Checks (Last 2 visits)
- ☐ Growth Charts (for age 12 or under)

Mental Health / Behavioral:

- ☐ Mental Health / Therapy Notes (Initial visit and last 2 visits)
- ☐ Psychological Evaluation / History
- ☐ Treatment Plans
- ☐ Discharge Summary

School / Learning Center:

- ☐ Psychological or Educational Tests
- ☐ IEP (Initial and latest follow-up)
- ☐ Plan 504 (Initial and latest follow-up)
- ☐ Discipline Referrals (Last 12 months)
- ☐ Suspensions (Last 12 months)
- ☐ ADHD/Behavioral Notes

☐ Other (please describe): _____

PURPOSE/USE OF REQUESTED INFORMATION:

- ☐ Sharing with other health care providers
- ☐ Personal use by patient
- ☐ Other (please describe): _____

I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.

I hereby, knowingly and voluntarily authorize Greenville ADHD Specialists to use or disclose my health information in the manner described above and my authorization will remain effective from the date of my signature until revocation. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Greenville ADHD Specialists' Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing. I understand that if the authorized recipient of this information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be no longer protected by these regulations and may be re-disclosed. I release Greenville ADHD Specialists from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Printed Name of Patient or Legal Guardian | Relationship to Patient (if signed by Legal Guardian)

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