

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

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:

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.



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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:	
Name of School:		Current Grade Level:	
Patient Preferred Language:		Parent/Guardian Preferred Language:	
1st Parent/Legal Guardian:		Relationship to Patient:	
Mailing Address:		Zip Code:	
Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Email:	
Please select your preferred method of contact for <u>automated appointment reminders</u>: <input type="checkbox"/> Email <input type="checkbox"/> Text			
2nd Parent/Legal Guardian:		Relationship to Patient:	
Mailing Address:		Zip Code:	
Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> 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 am aware that the most secure way to communicate is through the patient portal.

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:** _____

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: _____

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: _____

NOTICE OF PRIVACY PRACTICES

Effective 1/27/2026

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, without written authorization:

• **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. For example, we may share your medical information with other physicians or other health care providers who are directly involved in your care. Or we may share this information with a pharmacist if needed in order to dispense a prescription.

We may use and disclose PHI to contact you with appointment reminders or other health information related to your care by phone, email, text or through the patient portal. If you are not available, we may leave this information on your voicemail or with the person answering the phone. At an appointment, we may call out your name when we are ready to see you.

• **Healthcare Operations:** We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use your information to train or review the performance of our staff or make decisions affecting the practice.

• **Business Operations/Payment:** 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.

• **Other Uses or Disclosures:** We are allowed or required to share your information in other ways such as public health.

- As required by state or federal law: sharing information with the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, law enforcement purposes or with a law enforcement official, or for special government functions such as military or correctional institutions
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- For research purposes if certain conditions are satisfied
- Sharing information with a coroner, medical examiner or funeral director when an individual dies
- In response to a court order, warrant, or subpoena in judicial or administrative proceedings
- Exercise of professional judgement if individual is incapacitated or an emergency treatment circumstance arises
- Substance Use Disorder Records (42 CFR Part 2)

We may use and disclose your substance use disorder records subject to 42 CFR Part 2 for treatment, payment, and health care operations as permitted by law. We are prohibited from using or disclosing your substance use disorder records subject to 42 CFR Part 2 in any civil, criminal, administrative, or legislative proceedings against you without your specific written consent or a court order.

• **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.



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 to inspect or obtain a copy of your PHI for so long as we maintain the PHI. You may obtain an electronic or paper copy of 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. Your request may be restricted only in exceptional circumstances or with documents released to us. We will provide requested information within 30 days (with one 30 day extension when justified). 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, text, email, postal mail, etc.) We will accommodate reasonable requests.
- **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 may deny your request in writing within 30 days for certain reasons (Ex: if we did not create the record or if we determine that the record is accurate and complete).
- **Right to an Accounting of Disclosures.** You have the right to request a list (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 paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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. We will not retaliate against you for filing a complaint. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints

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: _____

BUSINESS POLICIES

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

- _____ 1. **Cancellation and Rescheduling Policy**
A minimum of **24 hours' notice** is required to reschedule or cancel an appointment in order to avoid 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. **How to Cancel or Reschedule**
Please **call or text the office at 864-305-1662** to cancel or reschedule your appointment. Messages from this number are *not automated*. Automated reminders are sent from **864-900-0343**. Please save both numbers in 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 office hours (typically Friday between 8 am – 12:00 pm, unless Friday is a holiday). The same applies to Tuesday appointments when Monday is a holiday.

- _____ 4. **Appointment Reminders**
As a courtesy, we provide appointment reminders by text or email. However, reminders are **not guaranteed** and may not be sent 24 hours in advance. Patients are responsible for tracking their own appointment dates and times.

- _____ 5. **Late Arrivals**
If you arrive late, we will make every effort to accommodate you. However, tardiness may reduce your time with the provider or require rescheduling, in which case the cancellation fee will apply.

- _____ 6. **Minors**
Patients under the age of 18 must be accompanied by a parent or legal guardian for every visit. If you wish for your child to attend an appointment alone or with another adult, a signed consent form must be on file **prior** to the appointment. Please request this form if needed.

- _____ 7. **In-State Patient Requirements**
All new patient appointments must be in person. For follow-up appointments, South Carolina residents are required by law to be seen **in person once per year** for updated vitals and a cardiovascular exam.

- _____ 8. **Out-of-State Patients**
All appointments for patients residing outside of South Carolina must be conducted **in person**, per state regulatory requirements.

- _____ 9. **Virtual Follow up Appointments**
Virtual appointments must be conducted via **Zoom with video enabled**. Required forms are sent prior to **every** Zoom appointment. Failure to complete these forms will result in loss of eligibility for virtual follow-up appointments, and future visits will be required in person.

_____ 10. **Provider Availability**

Providers are available **by appointment only**. Any communication between appointments (text, email or portal message) will be addressed by office staff and forwarded to your provider for review.

_____ 11. **Use of AI in Appointments**

AI technology may be used during appointments to support accurate documentation and allow for more active listening. If you do not consent to the use of AI, please inform our staff.

_____ 12. **Non-Discrimination and Language Access**

Greenville ADHD Specialists does not discriminate on the basis of national origin, language or disability. We take reasonable steps to ensure meaningful access for individuals with limited English proficiency and provide **qualified interpreter services at no cost**.

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.

_____ 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: _____

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

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 past 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates/Reasons:
Tonsillectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age:
Adenoidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age:
PE Tubes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age(s):
Other Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates/Description:

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

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
ODD- Oppositional Defiant Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Vocal Tics	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Motor Tics	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Self-Injury or Cutting	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other Psychiatric Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Have you ever worked with an ADHD coach?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When:	Who:	
Counseling/Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last visit:	Therapist:	
Any hospitalizations for mental health illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates:		
Reason:				Place:	

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

DEVELOPMENTAL HISTORY	
Any developmental delays (compared to others at the same age)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech	(single words, sentences) <input type="checkbox"/> Early <input type="checkbox"/> Average <input type="checkbox"/> Late
	Speech Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No Age of First Therapy: Age of Last Therapy:
Motor Skills	(sitting up, walking) <input type="checkbox"/> Early <input type="checkbox"/> Average <input type="checkbox"/> Late
	Physical Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No Age of First Therapy: Age of Last Therapy:
Fine Motor	(stacking blocks, drawing circle) <input type="checkbox"/> Early <input type="checkbox"/> Average <input type="checkbox"/> Late
	Occupational Therapy <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> N/A
	Middle school? <input type="checkbox"/> Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> N/A
	High school? <input type="checkbox"/> Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> N/A
How difficult is homework/studying?	
Behavior/Discipline Problems in School <input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:
Has the patient ever received IQ or Academic testing for learning problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when was testing?	Who performed testing?
Learning Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Math
	Testing <input type="checkbox"/> Yes <input type="checkbox"/> No Date: Performed by:
* Please bring copy of testing, 504 Plan, and/or IEP meetings/plans	
School Suspensions <input type="checkbox"/> Yes <input type="checkbox"/> No	When/Why:
Does the patient participate in any of the following:	
Resource Class? <input type="checkbox"/> Yes <input type="checkbox"/> No	Which subjects, how many hours?
Accelerated or Honors Courses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Which subjects?
IEP (Individual Education Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last meeting?
504 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last meeting?

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

List any after school or extracurricular activities:											
Exercise Habits	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks) <input type="checkbox"/> Occasional vigorous exercise (i.e., sports or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., sports or recreation 4x/week for 30 minutes)										
Dietary Habits	<input type="checkbox"/> Normal <input type="checkbox"/> Excessive Eating <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Craves Sugar										
Caffeine Intake	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><input type="checkbox"/> None</td> <td style="width: 20%;"><input type="checkbox"/> Coffee</td> <td style="width: 20%;"><input type="checkbox"/> Tea</td> <td style="width: 20%;"><input type="checkbox"/> Cola</td> <td style="width: 20%;"><input type="checkbox"/> Energy Drinks</td> </tr> <tr> <td>#cups/cans per day:</td> <td>#: </td> <td>#: </td> <td>#: </td> <td>#: </td> </tr> </table>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	<input type="checkbox"/> Energy Drinks	#cups/cans per day:	#:	#:	#:	#:
<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	<input type="checkbox"/> Energy Drinks							
#cups/cans per day:	#:	#:	#:	#:							

SLEEP HISTORY	
Problems Falling Asleep <input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems Staying Asleep <input type="checkbox"/> Yes <input type="checkbox"/> No	
Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Walking <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Talking <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restless Legs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty waking up in AM <input type="checkbox"/> Yes <input type="checkbox"/> No	
Night Terrors <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nightmares <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Study <input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Results:

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
<input type="checkbox"/> ADHD	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Panic Disorder	
<input type="checkbox"/> Bipolar Disorder	
<input type="checkbox"/> OCD- Obsessive Compulsive Disorder	
<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Substance Abuse/Addiction or Alcoholism	
<input type="checkbox"/> Learning Disabilities	
<input type="checkbox"/> Autism, Asperger's, Pervasive Developmental Disorder	
<input type="checkbox"/> Tic Disorder	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Migraines	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> High Cholesterol/Lipids	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Sudden Cardiac Death	
<input type="checkbox"/> TIA/Stroke	
<input type="checkbox"/> Cancer- type:	
<input type="checkbox"/> Other:	

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

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

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?

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



211 E. Butler Rd.
Suite C-1
Mauldin, SC 29662

P: 864-305-1662
F: 864-603-2067
www.GreenvilleADHD.com

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)