MATTHEW S. STUBBLEFIELD, MD

Child, Adolescent, and Adult Psychiatry
1260 N. Dutton Avenue, Suite 100
Santa Rosa, CA 95401
Phone: (650) 856-0406; FAX (650) 240-3880

PATIENT INFORMATION **Date:** _____

Patient's Name: _____ SS# ___-___-___ Sex: ☐ Male ☐ Female

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

Home Address: _____

Home Phone: (_____)_____Cell Phone: (_____)_____

Occupation: _____ ☐ Student

Employer (School, if student): _____ Work/School Phone: (_____)_____

Employer/School Address: _____

E-mail Address: _____ Fax Phone: (_____)_____

Driver's License Number: _____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ SS# ___-___-___ Date of Birth: _____

Home Address: _____

Home Phone: (_____)_____ Occupation: _____

Employer: _____ Work Phone: (_____)_____

Employer Address: _____ Driver's License No.: _____

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

Spouse's Name: _____ SS# ___-___-___ Date of Birth: _____

Spouse's Employer: _____ Address: _____

INSURANCE BILLING: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by your insurance.

PAYMENT POLICY: Payment for services is required at the time they are rendered. Payment may be made by cash, personal check, or credit card (MasterCard, Visa, or American Express). As patients are expected to maintain a zero balance, our office does not send patients statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 90 days old are routinely reviewed for submission to our collection agency.

FEES CHARGED: The fees charged are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled/charged is for a medication check-up (15-20 minutes in length). If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent with a patient on the telephone, time taken to electronically send prescriptions outside of scheduled appointments, consult others by phone, and write reports or correspondence on patient's behalf.

APPOINTMENT CANCELLATION POLICY: Cancellations for scheduled appointments must be received 24 hours in advance during regular office hours (Monday through Thursday 9am to 5pm). The office is currently closed on Fridays. **Not kept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee.** This fee can equal but will not exceed the fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees, and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies.

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

Adult Intake Questionnaire

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

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____
Birth Date _____ Age _____ Sex _____
Religion _____ Marital Status _____
Race _____ Children _____
Address _____ City _____ State ____ Zip _____
Home (_____)_____ Work (_____)_____
Who are you currently living with? _____

REFERRAL SOURCE _____
Address _____
Phone: (_____)_____FAX: (_____)_____ Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

_____

_____

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

_____

Name:_____

MEDICAL HISTORY

Current medical problems/medications:_____

_____

Current supplements/vitamins/herbs:_____

Past medical problems/medications: _____

_____

Other doctors/clinics seen regularly: _____

_____

Any history of head trauma? (describe): _____

_____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

_____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Present Height _____ *Present Weight* _____

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

_____

_____

_____

Prenatal and birth events: Your parents' attitudes toward their pregnancy with you _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc._____

_____

Any birth problems, trauma, forceps or complications?: _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

_____

_____

School History: Last grade completed _____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Learning strengths _____

Any behavior problems in school? _____

What have teachers said about you?_____

_____

Please bring school report cards and any state, national or special testing that has been performed.

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

_____

_____

_____

Any work-related problems? _____

What would your employers or supervisors say about you? _____

Name:_____

Military History? _____

Ever Any Legal Problems? _____

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

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

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

FAMILY HISTORY

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

Current Marital or Relationship Satisfaction_____
_____

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

History of Past Marriages _____
_____
_____

Name:_____

Natural Mother's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Mother's alcohol/drug use history _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Natural Father's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Siblings (names, ages, problems, strengths, relationship to patient) _____
_____
_____
_____

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

Cultural/Ethnic Background _____
_____

Describe your relationships with friends _____
_____
_____

Describe yourself _____
_____
_____

Describe your strengths _____
_____
_____
_____

Name:_____

Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

___ 1. depressed or sad mood
___ 2. decreased interest in things that are usually fun, including sex
___ 3. significant weight gain or loss, or marked appetite changes, increased or decreased
___ 4. recurrent thoughts of death or suicide
___ 5. sleep changes, lack of sleep or marked increase in sleep
___ 6. physically agitated or "slowed down"
___ 7. low energy or feelings of tiredness
___ 8. feelings of worthlessness, helplessness, hopelessness or guilt
___ 9. decreased concentration or memory
___ 10. periods of an elevated, high, or irritable mood
___ 11. periods of a very high self esteem or grandiose thinking
___ 12. periods of decreased need for sleep without feeling tired
___ 13. more talkative than usual or pressure to keep talking
___ 14. racing thoughts or frequent jumping from one subject to another
___ 15. easily distracted by irrelevant things
___ 16. marked increase in activity level
___ 17. excessive involvement in pleasurable activities that have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
___ 18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
___ 19. periods of trouble breathing or feeling smothered
___ 20. periods of feeling dizzy, faint or unsteady on your feet
___ 21. periods of heart pounding or rapid heart rate
___ 22. periods of trembling or shaking
___ 23. periods of sweating
___ 24. periods of choking
___ 25. periods of nausea or abdominal upset
___ 26. feelings of a situation "not being real"
___ 27. numbness or tingling sensations
___ 28. hot or cold flashes
___ 29. periods of chest pain or discomfort
___ 30. fear of dying
___ 31. fear of going crazy or doing something uncontrolled
___ 32. avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable
___33. excessive fear of being judged by others, which causes you to avoid or get anxious in situations
___ 34. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
___ 35. recurrent bothersome thoughts, ideas or images which you try to ignore
___ 36. trouble getting "stuck" on certain thoughts, or having the same thought over and over

Name:_____

___ 37. excessive or senseless worrying
___ 38. others complain that you worry too much or get "stuck" on the same thoughts
___ 39. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
___ 40. needing to have things done a certain way or you become very upset
___ 41. others complain that you do the same thing over and over to an excessive degree (such as cleaning or checking)
___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.) please list _____
___ 43. recurrent distressing dreams of a past upsetting event
___ 44. a sense of reliving a past upsetting event
___ 45. a sense of panic or fear to events that resemble an upsetting past event
___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
___ 47. persistent avoidance of activities/situations that cause remembrance of upsetting event
___ 48. inability to recall an important aspect of a past upsetting event
___ 49. marked decreased interest in important activities
___ 50. feeling detached or distant from others
___ 51. feeling numb or restricted in your feelings
___ 52. feeling that your future is shortened
___ 53. quick startle
___ 54. feels like you're always watching for bad things to happen
___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
___ 56. marked irritability or anger outbursts
___ 57. unrealistic or excessive worry in at least a couple areas of your life
___ 58. trembling, twitching or feeling shaky
___ 59. muscle tension, aches or soreness
___ 60. feelings of restlessness
___ 61. easily fatigued
___ 63. heart pounding or racing
___ 64. sweating or cold clammy hands
___ 65. dry mouth
___ 66. dizziness or lightheadedness
___ 67. nausea, diarrhea or other abdominal distress
___ 68. frequent urination
___ 69. trouble swallowing or "lump in throat"
___ 70. feeling keyed up or on edge
___ 71. quick startle response or feeling jumpy
___ 72. difficult concentrating or "mind going blank"
___ 73. trouble falling or staying asleep
___ 74. irritability
___ 75. trouble sustaining attention or being easily distracted
___ 76. difficulty completing projects
___ 77. feeling overwhelmed of the tasks of everyday living
___ 78. trouble maintaining an organized work or living area
___ 79. inconsistent work performance
___ 80. lacks attention to detail
___ 81. makes decisions impulsively
___ 82. difficulty delaying what you want, having to have your needs met immediately
___ 83. restless, fidgety

Name:_____

___ 84. make comments to others without considering their impact
___ 85. impatient, easily frustrated
___ 86. frequent traffic violations or near accidents
___ 87. refusal to maintain body weight above a level most people consider healthy
___ 88. intense fear of gaining weight or becoming fat even though underweight
___ 89. feelings of being fat, even though you're underweight
___ 90. recurrent episodes of binge eating large amounts of food
___ 91. a feeling of lack of control overeating behavior
___ 92. engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise
___ 93. persistent over-concern with body shape and weight
___ 94. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present? _____ How often?_____ describe_____
___ 95. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing,) How long have verbal tics been present? _____ How often?_____ Describe_____
___ 96. delusional or bizarre thoughts (thoughts you know others would think are false)
___ 97. seeing objects, shadows or movements that are not real
___ 98. hearing voices or sounds that are not real
___ 99. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others.
___ 100. social isolation or withdrawal
___ 101. severely impaired ability to function at home or at work
___ 102. peculiar behaviors
___ 103. lack of personal hygiene or grooming
___ 104. inappropriate mood for the situation (i.e., laughing at sad events)
___ 105. marked lack of initiative
___ 106. frequent feelings that someone or something is out to hurt you or discredit you
___ 107. periods of extreme irritability, physical or verbal aggression or rage with little provocation
___ 108. periods of confusion
___ 109. periods of spaciness or missing brief periods of time
___ 110. periods of fearfulness for no apparent reason
___ 111.periods of deja vu (feeling that you've experienced something before even though you never have)
___ 112. periods of unusual visual (seeing) or auditory (hearing) sensations or illusions
___ 113. periods of forgetfulness or memory problems
___ 114. do you snore loudly (or do others complain about your snoring)
___ 115. have others said you stop breathing when you sleep
___ 116. do you feel fatigued or tired during the day
___ 117. do you often feel cold when others feel fine, or they are warm
___ 118. do you often feel warm when others feel fine, or they are cold
___ 119. do you have problems with brittle or dry hair
___ 120. do you have problems with dry skin
___ 121. do you have problems with sweating

Name:_____

Learning Style Questionnaire

Reading

How well do you read? _____
Do you like to read? _____
When you read, do you make mistakes like skipping words or lines or reading the same line twice? _____
_____
Do you find that you don't remember what you read, even though you've read all the words?
_____

Writing

How is your handwriting? _____
How is your spelling, grammar, and punctuation? _____
_____
Do you have trouble copying off the board? _____
Do you usually write in cursive or print? _____
Do you have trouble getting thoughts from your brain to the paper? _____

Math

Do you know your multiplication tables? _____
Do you switch numbers around_____
Do you sometimes forget what you're supposed to be doing in the middle of a problem? _____

Sequencing

When you speak do you have trouble getting everything in the right order (switch words or ideas around)?
_____
_____
Can you name the months of the year without problems? _____
Do you have trouble using the alphabet in order? _____
Do you have to start from the beginning of the alphabet each time? _____

Abstraction

Do you understand jokes when your friends tell them? _____
Do you sometimes get confused when people seem to say something, yet you find out they meant something else? _____
_____

Organization

What does your notebook (room, desk, locker, book bag) look like? _____
_____
Are your papers organized or a mess? _____
Do you have multiple piles everywhere? _____
Do you have trouble organizing your thoughts or the facts you're learning into a whole concept? _____
_____

Do you have trouble planning your time?_____

Name:_____

Memory

Do you find that you can learn something at night and then forget what you learned the next day? _____

_____

_____

Do you sometimes forget what you're going to say right in the middle of saying it? _____

_____

Language

When someone is speaking do you have trouble keeping up or understanding what is being said? _____

_____

Do you misunderstand people and give the wrong answer? _____

_____

Do you have problems finding the right words to use?_____

_____

Name:_____

General Adult ADD Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture. Have another person who knows you well (such as a spouse, partner or parent) rate you as well. Other person is: _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Past History

Other Self

____ ___ 1. History of ADD symptoms in childhood, such as distractibility, short attention span, impulsivity or restlessness. ADD doesn't start at age 30.
____ ___ 2. History of not living up to potential in school or work. (Report cards with comments such as "not living up to potential.")
____ ___ 3. History of frequent behavior problems in school (mostly for males).
____ ___ 4. History of bedwetting past 5 years old.
____ ___ 5. Family history of ADD, learning problems, mood disorders or substance abuse problems.

Short Attention Span/Distractibility

Other Self

____ ___ 6. Short attention span, unless very interested in something.
____ ___ 7. Easily distracted, tendency to drift away (although at times can be hyper focused).
____ ___ 8. Lacks attention to detail, due to distractibility.
____ ___ 9. Trouble listening carefully to directions.
____ ___10. Frequently misplaces things.
____ ___11. Skips around while reading, or goes to the end first, trouble staying on track.
____ ___12. Difficulty learning new games because it is hard to stay on track during directions.
____ ___13. Easily distracted during sex, causing frequent breaks or turn-offs during lovemaking.
____ ___14. Poor listening skills.
____ ___15. Tendency to be easily bored (spaces out).

Restlessness

Other Self

____ ___16. Restlessness, constant motion, legs moving, fidgetiness.
____ ___17. Has to be moving in order to think.
____ ___18. Trouble sitting still, such as trouble sitting in one place for too long, sitting at a desk job for long periods, sitting through a movie.
____ ___19. An internal sense of anxiety or nervousness.

Impulsivity

Other Self

____ ___20. Impulsive, in words and/or actions (such as spending).
____ ___21. Say just what comes to mind without considering its impact (tactless).
____ ___22. Trouble going through established channels, trouble following proper procedure, an attitude of "read the directions when all else fails."
____ ___23. Impatient, low frustration tolerance.
____ ___24. A prisoner of the moment.
____ ___25. Frequent traffic violations
____ ___26. Frequent, impulsive job changes.
____ ___27. Tendency to embarrass others.
____ ___28. Lying or stealing on impulse.

Name:_____

Poor Organization

Other Self

____ ___29. Poor organization and planning, trouble maintaining an organized work/living area.
____ ___30. Chronically late or chronically in a hurry.
____ ___31. Often have piles of stuff.
____ ___32. Easily overwhelmed by tasks of daily living.
____ ___33. Poor financial management (late bills, checkbook a mess, spending unnecessary money on late fees).
____ ___34. Some adults with ADD are very successful, but often only if they are surrounded with people who organize them.

Problems Getting Started and Following Through

Other Self

____ ___35. Chronic procrastination or trouble getting started.
____ ___36. Starting projects and not finishing; poor follow-through.
____ ___37. Enthusiastic beginnings but poor endings.
____ ___38. Spends excessive time at work because of inefficiencies.
____ ___39. Inconsistent work performance.

Negative Internal Feelings

Other Self

____ ___40. Chronic sense of underachievement; feeling you should be much further along in your life than you are.
____ ___41. Chronic problems with self-esteem.
____ ___42. Sense of impending doom.
____ ___43. Mood swings.
____ ___44. Negativity.
____ ___45. Frequent feeling of demoralization or that things won't work out for you.

Relational Difficulties

Other Self

____ ___46. Trouble sustaining friendships or intimate relationships, promiscuity.
____ ___47. Trouble with intimacy.
____ ___48. Tendency to be immature.
____ ___49. Self-centered; immature interests.
____ ___50. Failure to see others' needs or activities as important.
____ ___51. Lack of talking in a relationship.
____ ___52. Verbally abusive to others.
____ ___53. Proneness to hysterical outburst.
____ ___54. Avoids group activities.
____ ___55. Trouble with authority.

Short Fuse

Other Self

____ ___56. Quick responses to slights that are real or imagined
____ ___57. Rage outbursts; short fuse.

Search for High Stimulation

Other Self

____ ___58. Frequent search for high stimulation (bungee jumping, gambling, racetrack, high stress jobs such as ER doctor, doing many things at once, etc.)
____ ___59. Tendency to seek conflict, be argumentative or to start disagreements for the fun of it.

Name:_____

Tendency to Get Stuck (Thoughts or Behaviors)

Other Self

____ ___60. Tendency to worry needlessly and endlessly.
____ ___61. Tendency toward addictions (food, alcohol, drugs, work).

Switches things around

Other Self

____ ___62. Switches around numbers, letters, or words.
____ ___63. Turns words around in conversations.

Writing/Fine Motor Coordination Difficulties

Other Self

____ ___64. Poor writing skills (hard to get information from brain to pen).
____ ___65. Poor handwriting (often prints).
____ ___66. Coordination difficulties.

The Harder I Try, The Worse It Gets

Other Self

____ ___67. Performance becomes worse under pressure.
____ ___68. Test anxiety, or during tests your mind tends to go blank.
____ ___69. The harder you try, the worse it gets.
____ ___70. Work or schoolwork deteriorates under pressure.
____ ___71. Tendency to turn off or become stuck when asked questions in social situations.
____ ___72. Falls asleep or becomes tired while reading.

Sleep/Wake Difficulties

Other Self

____ ___73. Difficulties falling asleep, may be due to too many thoughts at night.
____ ___74. Difficulty coming awake (may need coffee or other activity before feeling fully awake).

Low Energy

Other Self

____ ___75. Periods of low energy, especially early in the morning and in the afternoon.
____ ___76. Frequently feeling tired.

Sensitive to Noise or Touch

Other Self

____ ___77. Startles easily.
____ ___78. Sensitive to touch, clothes, noise and light.

Total Score: _____ (Add up all the "3's" and "4's" only. Count each "3" or "4" as 1 point)

Name:_____

Criteria for AD/HD Attention-Deficit/Hyperactivity Disorder (DSM-IV)

Check each of the following symptoms that has persisted for at least six months.

Inattention

____ 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
____ 2. Often has difficulty sustaining attention in tasks or play activities.
____ 3. Often does not seem to listen when spoken to directly.
____ 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
____ 5. Often has difficulty organizing tasks or activities.
____ 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework).
____ 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
____ 8. Is often easily distracted by extraneous stimuli
____ 9. Is often forgetful in daily activities.

Hyperactivity

____ 1. Often fidgets with hands or feet, or squirms in seat.
____ 2. Often leaves seat in classroom, or in other situations in which remaining seated is expected.
____ 3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
____ 4. Often has difficulty playing or engaging in leisure activities quietly.
____ 5. Is often "on the go" or often acts as if "driven by a motor."
____ 6. Often talks excessively.

Impulsivity

____ 7. Often blurts out answers before questions have been completed.
____ 8. Often has difficulty waiting for his/her turn.
____ 9. Often interrupts or intrudes on others (e.g., butts into conversations or games).

Name:_____

Hallmarks of ADD

Check each of the following symptoms that apply.

Without Hyperactivity

____ 1. Difficulty with sustained attention or erratic attention span
____ 2. Easily distracted by extraneous stimuli
____ 3. Excessive daydreaming
____ 4. Disorganized
____ 5. Responds impulsively or without thinking
____ 6. Problems completing things
____ 7. Doesn't seem to listen
____ 8. Shifts from one uncompleted activity to another
____ 9. Often complains of being bored
____ 10. Often appears to be apathetic or unmotivated
____ 11. Frequently sluggish or slow moving
____ 12. Frequently spacey or internally preoccupied

Depressive Subtype

____ 1. Difficulty with sustained attention or erratic attention span
____ 2. Easily distracted by extraneous stimuli
____ 3. Moodiness
____ 4. Negativity
____ 5. Low energy
____ 6. Irritability
____ 7. Social isolation
____ 8. Hopelessness, helplessness, excessive guilt
____ 9. Disorganization
____ 10. Lowered interest in things that are usually considered fun
____ 11. Sleep changes (too much or too little)
____ 12. Forgetfulness
____ 13. Chronic low self-esteem

Over-focused Subtype

____ 1. Difficulty with sustained attention or erratic attention span
____ 2. Easily distracted by extraneous stimuli
____ 3. Excessive or senseless worrying
____ 4. Disorganized or super-organized
____ 5. Oppositional, argumentative
____ 6. Strong tendency to get locked into negative thoughts, having the same thought over and over.
____ 7. Tendency toward compulsive behavior
____ 8. Intense dislike for change
____ 9. Tendency to hold grudges
____ 10. Trouble shifting attention from subject to subject
____ 11. Difficulties seeing options in situations
____ 12. Tendency to hold on to own opinion and not listen to others
____ 13. Tendency to get locked into a course of action, whether or not it is good for the person
____ 14. Needing to have things done a certain way or you become very upset
____ 15. Others complain that you worry too much
____ 16. A strong tendency to hold grudges, to hold on to hurts from the past

Explosive Subtype

____ 1. Difficulty with sustained attention or erratic attention span
____ 2. Easily distracted by extraneous stimuli
____ 3. Impulse control problems
____ 4. Short fuse or periods of extreme irritability
____ 5. Periods of rages with little provocation
____ 6. Often misinterprets comments as negative when they are not
____ 7. Irritability builds, then explodes, then recedes, often tired after a rage
____ 8. Periods of spaciness or confusion
____ 9. Periods of panic and/or fear for no specific reason
____ 10. Visual changes, such as seeing shadows or objects changing shape
____ 11. Frequent periods of deja vu (feelings of being somewhere before even though you never have)
____ 12. Sensitivity of mild paranoia
____ 13. History of a head injury or family history of violence or explosiveness
____ 14. Dark thoughts, may involve suicidal or homicidal thoughts
____ 15. Periods of forgetfulness or memory problems

Name:_____

Medical Review of Systems

Please place a check mark in the boxes that apply. Write any specific information next to the item for clarification.

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

Neurological
- ☐ Pacing due to muscle restlessness
- ☐ Decreased movement
- ☐ Forgotten periods of time
- ☐ Emotion causes brief paralysis
- ☐ Disorientation
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Muscle spasms or tremors
- ☐ Excessive clumsiness
- ☐ Impaired ability to remember
- ☐ Muscle stiffness
- ☐ "Tics"
- ☐ Nightmares
- ☐ Numbness
- ☐ Paralysis
- ☐ Tingling of "burning" feeling
- ☐ Convulsions/fits
- ☐ Slurred speech
- ☐ Speech Problem
- ☐ Fainting
- ☐ Shaking
- ☐ Spinning feeling
- ☐ Weakness (localized)
- ☐ Weakness (generalized)
- ☐ Other _____

Respiratory
- ☐ Asthma
- ☐ Cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Rapid breathing
- ☐ Coughing up sputum
- ☐ Repeated nose or chest colds
- ☐ Wheezing
- ☐ Other _____

Head, Eye, Ear, Nose & Throat

Head
- ☐ Facial pain
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Neck swelling
- ☐ Pain behind the ear
- ☐ Pain from jaw movement
- ☐ Pain in temple
- ☐ Scalp itching
- ☐ Other _____

Eye
- ☐ Blindness
- ☐ Blurred vision
- ☐ Bloodshot or red eye
- ☐ Double vision
- ☐ Feels something in eye
- ☐ Eye pain
- ☐ Farsightedness
- ☐ Increased tearing
- ☐ Itching of eyes
- ☐ Loss of vision from the side
- ☐ Nearsightedness
- ☐ Night blindness
- ☐ Overly sensitive to light
- ☐ Sees spots before eyes
- ☐ Other _____

Ear
- ☐ Hearing loss in both ears
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Feeling of fullness in ear
- ☐ Ear itching
- ☐ Ear ringing
- ☐ Hearing loss in one ear
- ☐ Other _____

Head, Eye, Ear, Nose & Throat, cont.

Nose
- ☐ Disturbances in smell
- ☐ Nosebleeds
- ☐ Nose stuffiness
- ☐ Nose itchiness
- ☐ Runny nose
- ☐ Sneezing
- ☐ Other _____

Mouth
- ☐ Dental (tooth or gum) problems
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Too much saliva in mouth
- ☐ Painful throat muscle spasms
- ☐ Frequent sore throat
- ☐ Sore tongue
- ☐ Taste alteration
- ☐ Tickling feeling in throat
- ☐ Other _____

Chest and Cardiovascular
- ☐ Ankle swelling
- ☐ Rapid/irregular pulse
- ☐ Breast swelling
- ☐ Breast mass
- ☐ Breast tenderness
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Nipple leaking milk
- ☐ Nipple bleeding
- ☐ Nipple discharge
- ☐ Breastbone tenderness
- ☐ Other _____

Musculoskeletal
- ☐ Back pain
- ☐ Back stiffness
- ☐ Bone pain
- ☐ Buttocks to ankle pain
- ☐ "Heavy" legs
- ☐ Calf pain on exercise
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Leg pain
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Repeated bone fractures
- ☐ Other _____

Name:_____

Medical Review of Systems (cont.)

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

Gastrointestinal and Hepatic

- ☐ Abdominal (stomach/belly) pain
- ☐ Anal (or rectal) pain
- ☐ Infrequent bowel movements
- ☐ Liquid bowel movements
- ☐ Trouble swallowing
- ☐ Loss of bowel control
- ☐ Frequent belching or gas
- ☐ Frequent solid bowel movements
- ☐ Heartburn (acid up to mouth)
- ☐ Vomiting blood
- ☐ Jaundice (yellowing of skin)
- ☐ Nausea (sick to stomach)
- ☐ Painful bowel movements
- ☐ Discharge/leakage near anus
- ☐ Anal itching
- ☐ Rectal bleeding (red blood)
- ☐ Return of food into the mouth
- ☐ Rectal bleeding (black blood)
- ☐ Bulky, foul-smelling stools
- ☐ Mucus in stools
- ☐ Pencil thin stools
- ☐ Pus in stools
- ☐ Vomiting (throwing up)

Male Genitourinary

- ☐ Itchy privates or genitals
- ☐ Painful urination
- ☐ Groin pain
- ☐ Blood in urine
- ☐ Impotence (weak male erection)
- ☐ Inability to ejaculate
- ☐ Frequent urination at night
- ☐ Insufficient urination
- ☐ Pain between thighs (not scrotum)
- ☐ Pus in urine
- ☐ Testicular (ball) swelling
- ☐ Scrotum (ball) pain
- ☐ Pain above pubic hair area
- ☐ Abnormal penis discharge
- ☐ Excessive urination
- ☐ Accidental wetting of self
- ☐ Difficulty in starting urine
- ☐ Excessive urgency to urinate
- ☐ Other _____

Female Genitourinary

- ☐ No menstrual period
- ☐ Itchy privates or genitals
- ☐ Vaginal bleeding with sex
- ☐ Painful menstrual periods
- ☐ Painful intercourse or sex
- ☐ Painful urination
- ☐ Groin pain
- ☐ Blood in urine
- ☐ Sterility/infertility
- ☐ Menstrual irregularity
- ☐ Frequent urination at night
- ☐ Insufficient urination
- ☐ Non-vaginal pain between thighs
- ☐ Pus in urine
- ☐ Pain above pubic hair area
- ☐ Excessive urination
- ☐ Accidental wetting of self
- ☐ Difficulty in starting to urinate
- ☐ Vaginal pain (not with sex)
- ☐ Abnormal vaginal discharge
- ☐ Vaginal bleeding between periods
- ☐ Other _____

Skin, Hair, and Lymph Nodes

- ☐ Drying of hair
- ☐ Dry skin
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Increased perspiration
- ☐ Abnormal change in mole(s)
- ☐ Tender lymph nodes
- ☐ Skin rash due to sun exposure
- ☐ Itchy skin
- ☐ Skin swelling
- ☐ Skin sore not healing
- ☐ Skin rash
- ☐ Skin ulcer/open sore
- ☐ Skin bleeds easily
- ☐ Sweaty palms
- ☐ Thinning hair
- ☐ Hives
- ☐ Other _____

Additional Explanations

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