

Neuro-Therapy Clinic, Inc.

Changing the Face of Mental Health

Dear Future Patient,

We appreciate the confidence you have placed in us by requesting an appointment. We realize you have options in choosing a clinic and want you to know we are dedicated to providing the highest quality care and we look forward to serving your psychiatric needs.

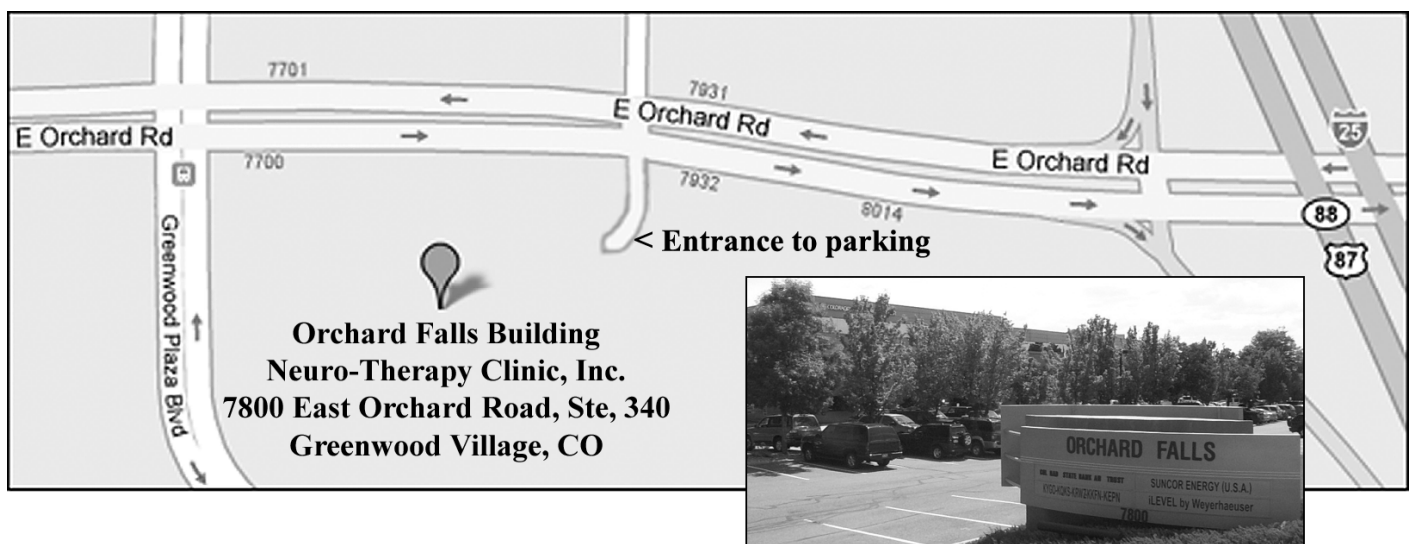
You are currently scheduled on _____ at _____ for an evaluation appointment.

Please remember the following when preparing for your appointment:

- Bring the attached paperwork to your appointment completed, including the enclosed medication list, with all past psychiatric meds you have been on, with dosages and any reactions you may have had. Please note that incomplete paperwork may prevent us from completing the initial evaluation in one session and may require you return again to complete the evaluation.
- Bring bottles of all psychiatric medications you are currently taking.
- Please arrive 15 minutes early for your first appointment. Late arrivals are subject to rescheduling and fees.
- Bring your insurance card and photo ID for identity verification.
- Please call your insurance company to verify coverage and to get pre-authorization if they require it.

Thank you in advance for your attention to the enclosed information. We look forward to meeting you. Should you have any questions or concerns please feel free to contact the office at (303) 741-4800.

~The Staff at Neuro-Therapy Clinic, Inc.



Directions from I-25: Take I-25 to the Orchard Exit Exit 198). Go west on Orchard, getting in the far left lane. Take a left at the first place you can go left. The building is on the right (the Orchard Falls Building) with parking all around.

REQUIRED INSURANCE INFORMATION

Please call your insurance company!

Patient Name: _____
Patient's SS#: _____
Patient's DOB: _____

Name of Insured Person _____
Insured's SS#: _____
Insured's DOB: _____

The following information can be found on your insurance card:

Insurance company: _____
Subscriber #: _____
(May be listed as Insured's SS#, Policy #, Member #, or ID #)

Employer: _____
Group #: _____
(May be listed as account #)

Member Services Phone #: (_____) _____

Mental Health Phone #: (_____) _____

Name of Mental Health Division: _____

Please call the Mental Health phone number on your insurance card (or Member Services number, if no Mental Health number is listed). Let the insurance representative know you need to know your MENTAL HEALTH BENEFITS.

Name of Person Contacted at Insurance Co. : _____ Date: _____

1. Are these providers in network?

Neuro-Therapy Clinic: Yes No
Daniel A. Hoffman, MD: Yes No
Debora Arrera, CNS, RXN: Yes No
Nicole Shadid, MD: Yes No

2. Is preauthorization needed for these CPT codes?

90801: Yes No 90805: Yes No
90862: Yes No 90807: Yes No

3. If "YES", ask for an authorization to be created:

What is the authorization #: _____
How many sessions is it for: _____
Start date: _____ End date: _____
What CPT codes are authorized: _____

4. Are these providers in network?

Jennifer Buchanan, LPC: Yes No
Jason Howard, LPC: Yes No
Mary Valuck, LCSW: Yes No

5. Is preauthorization needed for these CPT codes?

90801: Yes No
90806: Yes No

6. If "YES", ask for an authorization to be created:

What is the authorization #: _____
How many sessions is it for: _____
Start date: _____ End date: _____
What CPT codes are authorized: _____

7. Effective date of coverage: _____ **Benefits renew:** Calendar Year or Plan Year _____
Date

8. Individual Mental Health Deductible: \$ _____ **Amount of deductible met to date:** \$ _____
(Note: Our office will collect for your appointment in full according to the contracted rate with your insurance company if your deductible is not met.)

9. Co-Insurance: Patient _____% / Insurance _____% OR **Mental Health Copay:** \$ _____
Copay for Parity Diagnosis: \$ _____

10. Is there any of the following on this plan (circle)? Health Savings Account or Health Reimbursement Account or Flex Savings Account or Other _____ **How does it work?**

- Insurance company will send claim to HSA/HRA/FSA for processing and payment to NTC
- Patient has HSA/HRA/FSA credit card to use for payment
- Other (please explain): _____

10. Number of Mental Health visits allowed per year: _____ or Unlimited **# remaining this year:** _____

11. Billing address for Mental Health Claims: _____
(Usually different than address on insurance card)

NTC Staff Only:
Entered by _____
Date _____

POLICIES & PATIENT AGREEMENT (Please initial each section.)

Appointments: Due to the sensitive nature of matters discussed and in order for us to give our full attention to the person being evaluated, children may not come to the appointment, unless he/she is the one being evaluated. For patients under the age of 18, all persons with legal, medical decision-making authority should be present for the initial and any follow-up visits. In order to give you and our other patients the highest level care possible, if you are more than 15 minutes late and/or you haven't completed your paperwork it may be necessary to reschedule your appointment and you may incur a reschedule fee. We will make every effort to provide you with a "reminder" call for your first visit. Please note that reminder calls on subsequent appointments are done as a courtesy to our patients and are NOT guaranteed. We do have a program that can send you an appointment reminder automatically by email and/or text messages. You are welcome to sign-up for this service at your first visit.

Specialty: Dr. Hoffman is a Neuropsychiatrist, not a neurologist or a child and adolescent psychiatrist. We point this out as many insurance companies have Dr. Hoffman listed incorrectly since they don't have his specialty as an option in their systems. Debora Arrera, CNS, RXN, is a Clinical Nurse Specialist with an advanced degree in psychiatry. She has the ability to prescribe psychiatric medication.

General information on prescription refills: Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment, a 30-day supply at a time. Every time you have a medication management visit, he/she will send your prescriptions directly to your pharmacy electronically. Each time a prescription is sent to your pharmacy, it is assigned a new prescription number, making any old refill or prescription numbers obsolete. When refilling your medications, be sure to speak with a live pharmacist instead of using their automated system, to have them check for any refills or new prescriptions.

Medication Extensions: If you are an existing patient and will be out of a medication we've previously prescribed before you can get in for an appointment, we can extend that prescription for you, as long as you have the next appointment scheduled. We will only give you enough pills to get to that appointment. Medications refill requests called in to the clinic may take up to 72 business hours to fulfill.

Out-of-State Prescriptions: Due to state laws, we will not send your prescription to an out-of-state pharmacy.

90-day Supplies: Our clinic gets many requests from our patients for a 90-day supply of their medications or to have their prescriptions sent to a mail order pharmacy. In most cases, these mail order groups will only fill a prescription for 90 days at a time. Unfortunately, we cannot and will not approve 90-day supplies of any medication. As a rule, psychiatric and malpractice guidelines discourage the prescribing of 90 days worth of medication in one prescription. While for many of you this rule may increase your drug costs, it is created for the safety of patients to help in the prevention of drug overdoses, for which the psychiatric population is at higher risk. Even the FDA has warned "prescriptions for [medications] should be written for the smallest quantity of pills consistent with good patient management, in order to reduce the risk of overdose."

Conditions not suitable for our clinic: Adult patients with the following conditions/situations may not be able to be treated by our clinic and thus may be referred elsewhere for proper care: Significant acting out behavior including violence, anger or aggression, to include illegal or criminal behaviors; Psychiatric evaluations as required by probation, courts or work-related assessments; Patients needing monitoring of injectible medications; Substance abuse treatment as the chief complaint. For patients seeking care of general psychiatric conditions who also have substance abuse problems, we will require verification of treatment in a reputable substance abuse therapy. Please feel free to call us to provide more patient history so we can better advise you about the appropriateness of coming here for an appointment.

Cell Phones & Messages: It is important to note that cell phones may not be secure. If you are using a cell phone while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call. It may be necessary at times for our office to leave you a message at the phone numbers you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers.

Emergency Access: We try to service our clients whenever possible; however we are not a 24-hour facility. In case of an emergency, if you are unable to talk with your provider or have not received a call back within a couple of hours, call 911 or go to the nearest emergency room.

Missed, late, cancelled and “no show” appointments: As scheduled appointment times are reserved especially for you, all appointments are subject to charge, whether missed, unattended or canceled, unless there has been 2 business days notice given. In order to avoid being charged the full amount of the appointment you must call by 5 pm at least 2 business days prior to the appointment day. Please use the chart below for guidance. It is our policy that the time lost, not the reason, is what determines a charge. You may request a review of any missed, late cancellations or late appointment charges through a written letter to our Appeals Committee. Insurance companies do not pay for cancellation fees and, therefore, these charges will be your responsibility. Repeated “no show” appointments could result in treatment termination for non-compliance or in referral back to your insurance company for reassignment to another provider. We are open Monday through Friday from 8 am to 5 pm.

<u>If appt. is:</u>	<u>Cancel By:</u>
Monday	Preceding Thursday by 5 pm
Tuesday	Preceding Friday by 5 pm
Wednesday	Preceding Monday by 5 pm
Thursday	Preceding Tuesday by 5 pm
Friday	Preceding Wednesday by 5 pm

Insurance Verification: The information you receive when you call your insurance company is not a guarantee of payment and your insurance company may or may not pay for services. Once charges are submitted, the insurance company may determine benefits differently than they initially indicated. At any time during treatment should you become ineligible for insurance coverage or should your insurance coverage change please notify Neuro-Therapy Clinic (NTC) prior to your next appointment. You are responsible for obtaining prior authorization for treatment and for verifying the services you are coming here for are covered services by your insurance carrier or you will be responsible for payment in full at the time of service.

Limits of Confidentiality Statement: All information between practitioner and patient is held strictly confidential. There are legal exceptions to this: (1) The patient authorizes a release of information with a signature. (2) The patient’s mental condition becomes an issue in a lawsuit. (3) The patient presents as a physical danger to self or others. (4) Child or Elder abuse and/or neglect is suspected. (5) Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms). In the case of (3) or (4) above, our clinic is required by law to inform potential victims and legal authorities so that protective measures can be taken.

Consent for Treatment: I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Photo Authorization: I give authorization to NTC and their affiliates to obtain a photograph of me for my permanent medical record. I understand that the photograph is to help my providers assure proper patient identification and will not be copied or released. For patients under 18, a parent will be asked to be in the photograph as well.

HIPAA Privacy Practice Notice: I understand NTC follows HIPAA privacy guidelines which are outlined in their Notice of Privacy Practices, which is available at their office.

Release of Confidential Information to Primary Care Physicians and/or Referring Practitioners: It is a requirement of many insurance companies, as well as an acceptable protocol under HIPAA guidelines, that we communicate and coordinate with other healthcare professionals involved in your care. By signing below, I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. I authorize the release of necessary information to a collection agency should that become necessary. I authorize payment of medical benefits to NTC and its staff.

Payment Responsibility: Because we strive to provide a high level of care and a more thorough evaluation you may see two licensed professionals at your initial appointment, an Intake Specialist and a prescribing practitioner. Your insurance company requires that we bill them for both providers, which means that you are responsible for two copays, one per provider. Please note that if you have a deductible to meet, it is our office policy to collect in full for your appointments until your deductible is met. Any portion of your responsibility of payment (copays/coinsurance/deductible) is collected at the time services are rendered. Charges for services which are not benefits of the insurance plan are the patient's responsibility. These may include, but not be limited to: Some diagnostic testing; neurofeedback treatment; some telephone calls to a patient for consultation or medical management; intervention for medical management purposes on a patient's behalf with agencies, employers or insurance companies, including preauthorization for non-formulary medications; psychiatric evaluation of records, reports and other data for medical persons; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; missed appointment fees.

I understand that I am responsible for payment of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that NTC will submit any insurance claims for me, including those with or without a co-payment arrangement. I understand that if my insurance company denies payment or does not reimburse NTC within 60 days for services rendered, or reimburses NTC differently than they initially indicated, I will be personally responsible for payment, subject to interest of 1.5% per month on any unpaid balance. Services may be discontinued and your bill may be turned over to a collection agency if your account becomes delinquent and you will be responsible for payment of all legal and all other collection costs. There will be a \$35.00 service charge applied to your account for all returned checks. I understand that NTC will bill me directly for any balances due.

By signing below, I certify that I have read and understand these policies and agreements and have full knowledge of its meaning and effect.

Patient or Parent/Guardian Signature

Date

Patient Printed Name

CHILD AD/HD INTAKE EVALUATION (Attach additional sheets if needed)

Name: _____ Age: _____ Date: _____

Person completing this form: _____

Others present: _____

Are the patient's parents: Married Divorced/Separated Other _____

Please name all persons who have legal medical decision-making authority for this patient*: _____

*If applicable, please bring a copy of the court decree stating who has medical decision-making authority.

Staff Use Only:	Court decree brought in _____
	Accompanying adult instructed and agrees to get us copy of court decree _____

Current living situation (relationship of person(s) with whom patient resides)? _____

Are you interested in natural approaches to your treatment? Yes No

Allergies to medication:

_____	<input type="checkbox"/> Allergy	<input type="checkbox"/> Adverse Reaction	Please Describe: _____
_____	<input type="checkbox"/> Allergy	<input type="checkbox"/> Adverse Reaction	Please Describe: _____
_____	<input type="checkbox"/> Allergy	<input type="checkbox"/> Adverse Reaction	Please Describe: _____

Reason for this appointment:

What are the reasons you scheduled an appointment with our office? _____

How long have you had these symptoms? _____

Are these symptoms related to a life situation? Yes No If yes, please explain: _____

Do these symptoms seem to come and go regularly, as in a cycle? Yes No If yes, please describe: _____

Current medications: (IMPORTANT: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken) _____

Who has been prescribing your meds? _____

Name: _____

Date: _____

Medical History:

Do you have any of the following medical conditions? (check all that apply, use the space provided next to each condition to elaborate if needed)

- | | |
|--|---|
| <input type="checkbox"/> High/Low blood pressure _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Gastrointestinal problems _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Blood disorder _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other glandular disorder _____ |
| <input type="checkbox"/> Liver problems _____ | <input type="checkbox"/> Sleep disorder _____ |
| <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Headaches/Migraines _____ |
| <input type="checkbox"/> Respiratory problems _____ | <input type="checkbox"/> Pain disorder _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Other (please be specific) _____ |
| <input type="checkbox"/> Nervous system disorder _____ | |

When was your child's most recent physical? _____

Did their doctor have any concerns about their health? Yes No If yes, please describe: _____

Did they have any blood work done (i.e., thyroid testing)? Yes No

If yes, was anything abnormal? _____

Has your child or anyone in the genetic family had cardiovascular (heart) disease such as increased heart rate, irregular heart beat or a heart birth defect? If yes please describe: _____

Check any significant family medical illness or history:

- | | | |
|--|--|---|
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other glandular disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Nervous system disorder | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Pain disorder |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glucose intolerance and/or diabetes | <input type="checkbox"/> Thyroid disorder | |

Has your child experienced Post-Traumatic Stress Disorder (PTSD) or any traumas including physical, emotional or sexual abuse? Yes No

If yes, please describe: _____

How is your child's appetite? _____

Does your child become more hyperactive after eating:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Eggs | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Milk products | <input type="checkbox"/> Yellow food dye | <input type="checkbox"/> Red food dye |

Name: _____

Date: _____

Please check the boxes below for all that apply to your child:

- Runny or stuffy nose
- Frequent coughing or wheezing
- Dark circles or bags under the eyes
- Dry, flaky lips
- One or both ears red and/or burning
- Refusal to be touched
- Aggression such as biting, hitting, spitting, pinching, punching and kicking

Does your child have any family history of allergies? Yes No

If yes, please provide details: _____

Do you suspect your child has any food allergies? Yes No

If yes, please describe: _____

Have you consulted a doctor regarding this? Yes No

If yes, what was the outcome of the consultation? _____

Has your child had any recent changes in weight? Yes No

If yes, please describe: _____

ADD/ADHD Symptom Information:

Has your child previously been evaluated for ADD/ADHD? Yes No

If yes, please tell us who evaluated them, with what tests and what the results were: _____

What are the primary symptoms related to your child's ADD/ADHD:

- Attention
- Impulsivity
- Focus
- Distractibility
- Restless/always active
- Oppositional

Please describe these symptoms in more detail and how they are affecting your child's life in the following areas:

Home: _____

Name: _____

Date: _____

Relationships: _____

How long have these symptoms been a problem for your child?

Are these symptoms: Always present Intermittent

Please describe: _____

Sleep Habits:

Does your child have trouble falling asleep? Yes No

If yes, how long does it take for your child to fall asleep and please describe why your child has trouble if you know?

How is the quality of your child's sleep (e.g. light, deep, etc.)? _____

Does your child wake up in the middle of the night? Yes No

If so, how often and are they able to fall back to sleep? _____

Does your child seem to feel rested in the morning? Yes No Sometimes

Please check all that apply:

- My child snores
- My child has stopped breathing, gasps, snorts or thrashes in bed while sleeping
- My child has unexplained bedwetting
- My child experiences alterations in mood
- My child misbehaves to a greater degree than other children
- My child has poor school performance
- My child sleepwalks
- My child has night terrors

Please describe any items endorsed above: _____

What time does your child typically go to sleep and awaken? _____

Is it hard to awaken your child in the morning? Yes No

What kind of mood is your child usually in when he/she awakens? _____

Has your child ever had a sleep study? Yes No

Psychiatric History:

Has your child received any past psychiatric treatment or psychotherapy? Yes No

If yes, please list the names of the psychiatrists or therapists they have seen, why they were seen and for how long they were treated. _____

Name: _____

Date: _____

Has your child had any hospitalizations for a psychiatric condition? Yes No

If yes, please describe (include when, where, how long, what treatment did he/she receive and who was the treating psychiatrist). _____

Is your child currently in psychotherapy? Yes No

If yes, who is the therapist and how long has the child been seen? _____

If no, do you think therapy would be beneficial to your child or your family? Yes No

Is there any family genetic psychiatric history? Yes No

If yes, please be specific (who has what problem? on mother's or father's side?). If no formal diagnoses were made, what is your "gut" feeling about your family genetic psychiatric history? _____

Has there been any past history or has your child expressed any thoughts of harming themselves or anyone else (thoughts, plans, attempts, cutting, self-mutilation, passive thoughts of wishing they weren't here, etc.)? Yes No

If yes, please describe: _____

Support System:

Do you feel that your child has a support system? Check all that apply:

Family School Friends Other:

Head Injuries:

Has your child ever had any head injury, sports injury to the head, falls, concussions or car accidents?

Yes No (If no, skip to next section) Don't Know

If yes, describe where on the head the injury occurred and at what age: _____

Was there any loss of consciousness or amnesia? Yes No

Has there been any change in mood or memory since the head trauma occurred? Yes No

If yes, please describe: _____

Was your child hospitalized for the head injury? Yes No

If yes, please describe: _____

Name: _____

Date: _____

Was any type of scan performed (CAT scan, MRI, EEG, etc.)? Yes No Don't know
If yes, what did it show? _____

Childhood/Cultural History:

Describe your child's family life (include if family is intact, if parents are divorced and if so how old your child was, any custody arrangements, etc.) _____

Please tell us who lives with the child:

Name: _____ Relationship: _____ Age: _____

Was the child adopted? Yes No If yes, please tell us about the adoption: _____

Are there any cultural or spiritual factors that you would like to tell us about? _____

Legal History:

Has your child ever been involved in the legal system? Yes No

If yes, please explain: _____

Is your child presently on diversion or probation? Yes No

If yes, what are the requirements of their diversion or probation? _____

Name: _____

Date: _____

Do any genetic relatives have a history of problems with alcohol or substance abuse? Yes No
If yes, which relative(s)? _____

For Menstruating Female Patients only:

Does your child have regular periods? Yes No N/A
If no, please describe: _____

At what age did she start menstruating? _____

Does she have any PMS symptoms? Yes No N/A
If yes, please describe including how many days of her cycle the symptoms last: _____

School performance (If patient is out of school, complete as to what did occur):

Current grade & school (if applicable): _____

How does the patient do in school? (In grade school and high school; what do teachers say; do they live up to their academic potential; absences, tardiness, alertness in class, etc.). _____

Were any grades repeated? If so, which ones? _____

On average, what grades does the student receive? _____

Has school performance gotten worse as they've gotten older? _____

In what grade did you notice a decline in grades? _____

Is homework an issue in receiving poor grades? Yes No

Does the student complete homework? Yes No

Does the student forget to turn in homework? Yes No

Is there a variation in grades from year to year or subject to subject? Yes No

If so, please explain: _____

What subjects are the biggest struggles? _____

Are these struggles related to the subject matter or the teacher? _____

If problems are in math, does the student struggle with retention of math facts or comprehension of how to solve the problem? _____

Name: _____

Date: _____

What is the best subject(s) for the student? _____

What was unique or different about the student's favorite teacher? _____

Does the student receive any special education assistance or tutoring, either now or in the past? Yes No
If yes, what kind? _____

Does the student have an IEP (Individualized Education Program) or 504? Yes No

If so, please bring a copy to the evaluation.

Do you understand why the student has an IEP or 504? If so, please describe your understanding of it.

Do you feel that the school has followed through with the suggested accommodations described in the IEP or 504?

ADD/ADHD/Learning Disorder Background Information:

Are there any ADD/ADHD/Learning Disorders or Behavioral Problems in the family genetics? Yes No

If so, in whom (also state whether it was on mother's or father's side)? If no formal diagnosis was ever made, what is your "gut" feeling about this question? _____

Were there any problems in pregnancy or birth (i.e. cord wrapped around neck or ankle, oxygen required at birth, etc.)?

What was the patient's Apgar score, if known? _____

Were there many ear infections as a child? Yes No

If yes, how many would you estimate: <5 5-10 >10

Were tubes ever surgically inserted? Yes No

Were any antibiotics taken? Yes No

If yes, which ones? _____

How does the patient get along with friends and peers (e.g., isolated, age appropriate, attention seeking, respect for other's personal space and possessions, oppositional, aggressive, etc.)? _____

Name: _____

Date: _____

Any other miscellaneous information we should know? _____

Developmental Milestones: Check any of the following that may apply. As an infant, the patient usually:

- Was restless, squirmy, into everything
- Had difficulty in how they handled change in routine
- Protested when first introduced to new foods, places, or people
- Was intense and/or loud
- Was unpredictable in feeding and sleeping
- Was sensitive to noise, texture, clothing
- Was fussy and unhappy
- Did not enjoy cuddling
- Was not calmed by holding or stroking
- Had colic
- Had sleep problems
- Was hard to arouse while asleep
- Had bedwetting or problems with soiling (until what age _____)

Behavior/Characteristics: Check any of the following symptoms that apply to the patient (off medication) either now or in the past:

- Fails to pay attention to details or is careless
- Has difficulty organizing tasks and activities
- Is forgetful in daily activities
- Doesn't seem to listen to what is being said
- Avoids, dislikes or is reluctant to engage in tasks requiring sustained mental effort
- Is easily distracted by external stimuli
- Neither follows through on instructions nor completes chores, schoolwork or jobs (not because of oppositional behavior or failure to understand)
- Loses things
- Has trouble keeping attention on tasks or play
- Shifts from one uncompleted activity to another
- Has difficulty remaining seated
- Has difficulty awaiting turns
- Blurts out answers to questions before they have been completed
- Has difficulty playing quietly
- Talks excessively
- Interrupts or intrudes on others
- Squirms in seat or fidgets
- Inappropriately runs or climbs
- Appears driven or "on the go"

Name: _____

Date: _____

Did your child eat or lick paint? Yes No

If yes, please describe: _____

Did your child eat any non-food items? Yes No

If yes, please describe: _____

Did your child have any of the following symptoms?

Gastrointestinal problems: chronic diarrhea/constipation after 1 year of age

Sleep problems: problems falling asleep and/or waking during the night

Low muscle tone: general muscle weakness

Excessive salivation/drooling

Thrush: white yeast infection in the mouth

If you checked any of the above, please describe: _____

Did your child experience a period of major regression, during which they lost important skills? Yes No

If yes, please explain: _____

How old was the home where your child spent their infancy through toddler years? _____

Did your child spend any appreciable time in a home older than 20 years? _____

Is your child regularly around any antique furnishings? Yes No

If yes, please explain: _____

Does your child have any fillings? Yes No

If yes, are they: composite mercury

Did the mother breastfeed? Yes No

If yes, how long did the mother nurse? _____

How often did the mother eat seafood? _____

Did the mother have a Rhogam shot (due to an Rh difference between mother and child)? Yes No

Did the mother have any vaccinations during your pregnancy/breastfeeding? Yes No

If yes, please explain: _____

Did the mother do any painting or reside in a home that had been recently painted during your pregnancy or before it?

Yes No

During pregnancy:

Did the mother smoke while she were pregnant and/or breastfeeding? Yes No

If yes, please estimate the number of cigarettes per day: _____

Name: _____

Date: _____

Was the mother exposed to second-hand smoke due to spouse, officemates, or any others? Yes No
If yes, please estimate the extent: mild/infrequent moderate severe

Did the mother take a prenatal supplement? Yes No

Did the mother use any pesticides in her home during your pregnancy? Yes No
If yes, list the number of times: _____

Did the mother have any dental work done while pregnant? Yes No
If yes, please explain: _____

MEDICATION HISTORY

Name:

Date:

Instructions: Check the box next to the names of any medications that you have EVER taken, and complete the remaining boxes as completely as possible.

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr			List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)
Selective Serotonin Reuptake Inhibitors (SSRIs)					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Celexa	citalopram		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lexapro	escitalopram		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Luvox	fluvoxamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Paxil	paroxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prozac	fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zoloft	sertraline		/	/	-1 0 1 2 3 9		1 2 3	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)								
<input type="checkbox"/> Cymbalta	duloxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Effexor	venlafaxine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pristiq	desvenlafaxine		/	/	-1 0 1 2 3 9		1 2 3	
Other Antidepressants								
<input type="checkbox"/> Desyrel	trazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> ECT			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Remeron	mirtazapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Serzone	nefazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Wellbutrin	bupropion		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Aplenzin	bupropion hydrobromine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Venlafaxine ER	Venlafaxine hydrochloride		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Viibryd			/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
<i>Tricyclic Antidepressants</i>					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Adapin	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Anafranil	clomipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Asendin	amoxapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Endep/Elavil	amitriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ludiomil	maprotiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Norpramin	desipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pamelor/Aventyl	nortriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sinequan	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Surmontil	trimipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tofranil	imipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Vivactil	protriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<i>Monoamine Oxidase Inhibitors (MAOIs)</i>								
<input type="checkbox"/> Eldepryl/EMSAM	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Manerix	moclobemide		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Marplan	isocarboxazid		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Nardil	phenelzine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Parnate	tranylcypromine		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Stimulants					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Adderall	dexlevoamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Concerta	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Cylert	pemoline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Daytrana			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Dexadrine	dextroamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Eldepryl	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Focalin	dexmethylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Intuniv			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Nuvigil	armodafinil		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Provigil	modafinil		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ritalin	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Strattera	atomoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Vyvanse			/	/	-1 0 1 2 3 9		1 2 3	
Anti-Convulsants/Mood Stabilizers								
<input type="checkbox"/> Depakote, Depakene	valproic acid		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Eskalith, Lithobid	lithium carbonate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Keppra	levetiracetam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lamictal	lamotrigine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lyrica	pregabalin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Neurontin	gabapentin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tegretol, Eptol, Carbatrol	carbamazepine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Topamax	topiramate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Trileptal	oxcarbazepine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zonegran	zonisamide		/	/	-1 0 1 2 3 9		1 2 3	
Beta Blockers								
<input type="checkbox"/> Inderal	propranolol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pindolol			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tenormin	atenolol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Toprol	metoprolol		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
<i>Minor Tranquilizer / Hypnotics</i>					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Ambien	zolpidem		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Atarax	hydroxyzine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ativan	lorazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Benedryl	diphenhydramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Buspar	buspirone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Dalmane	flurazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Doral	quazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Halcion	triazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Klonopin	clonazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Librium	hlordiazepoxide		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lunesta	eszopiclone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prosom	estazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Restoril	temazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Rozerem	ramalteon		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Serax	oxazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sonata	zaleplon		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tranxene	clorazepate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Unisom	doxylamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Valium	diazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Xanax	alprazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/>	chloral hydrate		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response -1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	Side Effects List any that occurred while taking that medication	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr			1. Lack of therapeutic Effect	2. Side Effects (describe below)
Major Tranquilizers/Atypicals					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Abilify	aripiprazole		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Clozaril	clozapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Geodon	zipazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Haldol	haloperidol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Invega	paliperidone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Loxitane	loxapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Mellaril	thioridazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Moban	molindone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Navane	thiothixene		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prolixin	fluphenazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Risperdal	risperdone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Saphris	asenapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Seroquel	quetiapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sonazine, Thorazine	chlorpromazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Stelazine	trifluoperazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Symbyax	olanzapine/fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Trilafon	perphenazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zyprexa	olanzapine		/	/	-1 0 1 2 3 9		1 2 3	
Others								
	verapamil		/	/	-1 0 1 2 3 9		1 2 3	
	Cerepholin NAC		/	/	-1 0 1 2 3 9		1 2 3	
	Deplin		/	/	-1 0 1 2 3 9		1 2 3	

Childhood Symptoms (For Child Patients Only)

Name: _____

Date: _____

Circle the number next to each behavior your child currently exhibits or has exhibited in the past.

1. Is excessively distressed when separated from family
2. Exhibits excessive anxiety or worry
3. Has difficulty arising in AM
4. Is hyperactive and excitable in PM
5. Sleeps fitfully or has difficulty getting to sleep
6. Has night terrors or frequently wakes in the middle of the night
7. Is unable to concentrate at school
8. Has poor handwriting
9. Has difficulty organizing tasks
10. Has difficulty making transitions
11. Complains of being bored
12. Has many ideas at once
13. Is very intuitive or very creative
14. Is easily distracted by extraneous stimuli
15. Has periods of excessive, rapid speech
16. Is willful and refuses to be subordinated
17. Displays periods of extreme hyperactivity
18. Displays abrupt, rapid mood swings
19. Has irritable mood states
20. Has elated or silly, giddy mood states
21. Has exaggerated ideas about self or abilities
22. Exhibits inappropriate sexual behavior
23. Feels easily criticized or rejected
24. Has decreased initiative
25. Has periods of low energy or withdraws or isolates self
26. Has periods of self-doubt and poor self-esteem
27. Is intolerant of delays
28. Relentlessly pursues own needs
29. Argues with adults or bosses others
30. Defies or refuses to comply with rules
31. Blames others for his or her mistakes
32. Is easily angered when people set limits
33. Lies to avoid consequences of actions
34. Has protracted, explosive temper tantrums or rages
35. Has destroyed property intentionally
36. Curses viciously in anger
37. Makes moderate threats against others or self
38. Has made clear threats of suicide
39. Is fascinated with blood and gore
40. Has seen or heard hallucinations

TOTAL _____