

ADHD Preliminary Evaluation Form

Patient name: _____
 DOB: _____ Office/PMID: _____
 Date of Encounter: _____
 Allergies: _____

<p>HPI: Patient presents for evaluation for ADHD because of concerns expressed by: <input type="checkbox"/> Parent <input type="checkbox"/> Teacher <input type="checkbox"/> Other caregiver: _____</p>		<p>Chronic medications _____ _____ _____</p>		
<p>Were symptoms present before 7 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>Symptoms of hyperactivity: Longer than six months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>In the home (six or more)</i> <input type="checkbox"/> Runs through the home <input type="checkbox"/> Jumps/climbs excessively on furniture <input type="checkbox"/> Will not sit still to eat <input type="checkbox"/> Will not remain still to be read to <input type="checkbox"/> Will often interrupt <input type="checkbox"/> Fidgets when watching television <input type="checkbox"/> Makes disruptive noises <input type="checkbox"/> Always "on the go" or "driven by motor" <input type="checkbox"/> Crabs from others <input type="checkbox"/> Poor relationship with family members</p> <p><i>Symptom severity by parental report</i> <input type="checkbox"/> Mild compared to peers <input type="checkbox"/> Moderate compared to peers <input type="checkbox"/> Severe compared to peers</p>	<p><i>At school (six or more)</i> <input type="checkbox"/> Fidgets with hands/feet <input type="checkbox"/> Squirms in seat <input type="checkbox"/> Often leaves seat in classroom <input type="checkbox"/> Has difficulty with quiet play <input type="checkbox"/> Often blurts out answers <input type="checkbox"/> Poor school work (homework) <input type="checkbox"/> Poor school performance (grades) <input type="checkbox"/> Has difficulty awaiting turn <input type="checkbox"/> Poor relationship with classmates</p> <p><i>Symptom severity by teacher report</i> <input type="checkbox"/> Mild compared to peers <input type="checkbox"/> Moderate compared to peers <input type="checkbox"/> Severe compared to peers</p>	<p><i>Other social situations, (e.g., sports, day care, church, playground)</i> _____ _____ _____</p>		
<p>Symptoms of inattention: Longer than six months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>In the home (six or more)</i> <input type="checkbox"/> Has difficulty sustaining attention <input type="checkbox"/> Doesn't listen when spoken to <input type="checkbox"/> Doesn't follow through on instructions <input type="checkbox"/> Doesn't finish homework assignments <input type="checkbox"/> Has difficulty organizing tasks <input type="checkbox"/> Easily distracted by environment <input type="checkbox"/> Forgetful in daily activities</p> <p><i>Symptom severity by parental report</i> <input type="checkbox"/> Mild compared to peers <input type="checkbox"/> Moderate compared to peers <input type="checkbox"/> Severe compared to peers</p>			<p><i>At school (six or more)</i> <input type="checkbox"/> Doesn't pay attention to detail <input type="checkbox"/> Careless mistakes on homework <input type="checkbox"/> Shorter attention span than peers <input type="checkbox"/> Forgets to turn in homework <input type="checkbox"/> Often loses school supplies <input type="checkbox"/> Has difficulty organizing tasks <input type="checkbox"/> Easily distracted by environment</p> <p><i>Symptom severity by teacher report</i> <input type="checkbox"/> Mild compared to peers <input type="checkbox"/> Moderate compared to peers <input type="checkbox"/> Severe compared to peers</p>	<p><i>Other social situations (describe)</i> _____ _____ _____</p>
<p>PMHx Medical Problems</p> <p>History of injuries <input type="checkbox"/> Yes <input type="checkbox"/> No Learning disability <input type="checkbox"/> Yes <input type="checkbox"/> No Mood disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Schizophrenia <input type="checkbox"/> Yes <input type="checkbox"/> No Psychotic disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>SHx Family discord <input type="checkbox"/> Yes <input type="checkbox"/> No Recent stresses (e.g., relocation, death) <input type="checkbox"/> Yes <input type="checkbox"/> No New sibling <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>FHx Attention problems <input type="checkbox"/> Yes <input type="checkbox"/> No Learning disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Mental retardation <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Mood disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Tourette's <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

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<p>Evaluations Laboratory (optional) CBC <input type="checkbox"/> no anemia <input type="checkbox"/> to be done Glucose <input type="checkbox"/> normoglycemic <input type="checkbox"/> to be done TSH <input type="checkbox"/> euthyroid <input type="checkbox"/> to be done Other: _____</p> <p>School evaluation (recommended): _____</p> <p>Neuropsychiatric testing (optional): _____</p>	<p>Differential diagnoses</p> <p>Vision problem <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Hearing loss <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Seizure disorder (petit mal) <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Retardation <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Learning disability <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Developmental delay <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Possibility of abuse <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Adjustment disorder <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Substance abuse <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Mood disorder <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Tourette's syndrome <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Opposition defiant disorder <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely Conduct disorder <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely</p>
<p>Physical Exam Ht: _____ Wt: _____</p> <p>General: _____</p> <p>HEENT: _____</p> <p>Neck: _____</p> <p>Lungs: _____</p> <p>CV: _____</p> <p>Abd: _____</p> <p>Ext: _____</p> <p>Skin: _____</p> <p>Neuro: _____</p> <p><i>Cranial nerves -</i> Sensation - _____ Coordination - _____ Gait - _____</p> <p><i>Rouxberg -</i> DTR's and Babinski _____</p>	<p>Counseling Time spent counseling: >50% of 10 or 25 or 40 minute visit Comments _____</p> <p>Review of data <input type="checkbox"/> Reviewed teacher's behavioral scales <input type="checkbox"/> Reviewed parent/caregiver's behavioral scales <input type="checkbox"/> Reviewed samples of school work or teacher homework reports Other _____</p>
<p>Assessment/Plan Diagnosis <input type="checkbox"/> ADHD - predominantly hyperactive/impulsive type (314.01) <input type="checkbox"/> ADHD - predominantly inattentive type (314.01) <input type="checkbox"/> ADHD - combined type (314.01) <input type="checkbox"/> Inattention or hyperactivity of less than 6 months duration (312.9) <input type="checkbox"/> Adjustment reaction (309.0) <input type="checkbox"/> Mood disorder (specify): _____ <input type="checkbox"/> Learning disability (315.2) <input type="checkbox"/> Behavioral disturbance (312.9) <input type="checkbox"/> Conduct disorder (312.8) Medication plan <input type="checkbox"/> Start _____ at _____ mg _____ times per day. Will reassess effect of medication in _____ month (s) <input type="checkbox"/> Risks and benefits of medicines discussed <input type="checkbox"/> No need for medications at this time Behavior plan <input type="checkbox"/> Home behavioral modifications discussed <input type="checkbox"/> School behavioral modifications discussed <input type="checkbox"/> Recommend individual patient counselling <input type="checkbox"/> Recommend family counselling</p> <p>Follow up Pt was instructed to see _____ in _____ days or _____ weeks or _____ months</p>	<p>Other findings: Vision screen: _____ Hearing screen: _____ Other findings: _____</p> 