

New Patient Form

Name of the Patient: _____ Date of Birth: _____

Address: _____ Gender: _____

Patient lives with:

Both parents One parent Grandparents Any Relatives

Foster care Other _____

Have your child ever been diagnosed with ADHD?

Have your child ever been on ADHD medicines?

Does your child has any other significant medical illness like diabetes, autism, bipolar disorder, migraines, depression, genetic abnormalities.

Is your child taking any medicines? If yes which medicine and for what diagnosis

Does your child goes to in person school?

Have you contemplated giving ADHD medicines to your son/daughter?

Please complete this for parents:

Name of Mother: _____ Occupation: _____ Gender: _____

Name of Father: _____ Occupation: _____ Gender: _____