1. ADHD/Anxiety/Behavior Basic History

Medical professional interview

Name:_____

Birth date: _____Today's date _____ Age: _____

Address: _____

City_____State_____Zip_____

Parent/Guardian

Mother_____Father_____

Cell: _____Home:_____

Other: _____

Email: _____

Previous Primary Physician: _____

Location_____

Phone: _____Fax:_____

Other consultants: (*e.g.,* neurologist, psychiatrist, psychologist, counselor, immunologist, their contact numbers and location) Name:_____ Location _____

Phone:_____ Fax_____

Insurance Company: _____ Insurance ID number: _____

Symptoms/Complaints/Concerns:

_____

_____

_____

Family unit

Who lives in home: _____

Describe family dynamics/support system: _____

_____

_____

Second home? Y/N If so, who lives there?_____

PERINATAL HISTORY

Gestational age (weeks): _____ Birth weight_____Birth length if known_____
Small for gestational age? Y / N. Large for gestational age? Y / N.
Problems with pregnancy? Y / N. Describe_____
Problems with delivery? Y / N _____
Problems at birth? Y / N. Describe _____
_____
Problems in the newborn period Y / N? _____

INFANCY HISTORY

Problems in the first year of life? Y / N _____
Breast fed? Y / N. If so, how long _____
Colic/feeding intolerances_____
Other infancy problems _____

ALLERGY HISTORY

Food intolerances before onset of symptoms? Y / N. Food and reaction:_____
_____

Intolerance/allergy to medicines. Y / N. Medicines and reactions: _____
_____

Nasal allergy/hayfever/allergic rhinitis? Y / N. Allergic to what, if known?_____

Asthma requiring medicine every day Y / N? Asthma requiring medicines as needed? Y / N

Other allergies? Y / N to what and what reactions? _____
_____

Allergy to (circle one or more): Animal/Pollen/other environmental allergies/none

Allergy symptoms: change since symptom onset (circle one) Increase / decrease / no change

CURRENT MEDICATIONS

Please include hormones, psychiatric, behavioral medications, infusions like IVIG or steroids, steroids, creams, topical, supplements, vitamins, herbal remedies, other over the counter meds like nonsteroidal anti-inflammatory meds like acetaminophen, naproxen, etc.

Name	Dosage/interval	Date started	Ordering physician	Improved Symptoms Yes	No	worse

PREVIOUS MEDICATIONS:

Please include hormones, psychiatric, behavioral medications, infusions like IVIG or steroids, steroids, creams, topical, supplements, vitamins, herbal remedies, other over the counter meds like nonsteroidal anti-inflammatory meds like acetaminophen, naproxen, etc.

Name	Dosage/interval	Date started	Ordering physician	Improved Symptoms Yes	No	worse

ABOUT HOW MANY LIFETIME COURSES OF ANTIBIOTICS WERE GIVEN BEFORE SYMPTOM ONSET _____

IMMUNIZATION REACTIONS

Any history of immunization reactions Y / N? If so,

INFLUENZA VACCINE: Y / N IM / INTRANASAL
date_____ Reaction:_____

Vaccine _____
date_____ Reaction:_____

Vaccine _____
date_____ Reaction:_____

Vaccine _____
date_____ Reaction:_____

INFECTIONS AND TRIGGERING FACTORS

Before onset, did child have more infections than siblings or peers? Yes / No

Since onset, has child had *more* infections than siblings or peers? Yes / No

Do symptoms often worsen a day or more *after* infections Yes / No

Are symptoms usually worse *during* infections Yes / No

Do symptoms often worsen 1-3 days *before* infections? Yes / No

Does stress increase symptoms? Yes / No

Do symptoms increase without an apparent cause? Yes / No

COURSE

Prior / Prodromal symptoms

Months or years before onset, were there any similar, but milder past symptoms Y / N.
If yes, describe:

_____

Onset and first month

Today's date:_____
Date of onset: _____(nearest possible). Age at onset _____
Was onset abrupt/rapid? Gradual? Y / N. Always present Y / N.
If rapid, estimate time from first onset to worst symptoms: _____(hours/days).

Inciting events preceding the onset (please check all that apply)

No preceding infection___
Infections: Strep yes/ no Other infection_____
How long before the onset? _____

If Strep-associated onset (From Strep diagnosis table):
Definite / Probable / Possible / not Strep

Stress (e.g., starting school/family changes, etc.): _____

Description of the course

Estimate the total number of separate episodes lasting at least a week: (if not episodic, circle 1)
1 2 3 4-6 6-12

Course pattern (select one)
__ Episodic with return to normal between episodes
__ Episodic not returning to normal between episodes
__ Not episodic
__ Uncertain

Overall course (select one)
__ increasing over time.
__ improving over time.
__ about the same level over time
__ Uncertain

FAMILY HISTORY

	Primary: Mother, Father, Brother, Sister. M F B, S			Secondary: Grandparent (MGM…) Aunt/uncle (MA…) Half-sibling (MHB…)	More distant: Cousin Great grandparent etc.
Symptoms similar to patient					
ADHD					
Obsessions / compulsions					
Hoarding					
Anxiety requiring treatment					
Separation anxiety					
Tics / Tourette's					
Other movement disorder					
Rages/Anger issues					
Excessive alcohol use					
Manic/depressive/bipolar					
Autism/schizophrenia					
Other personality disorders					
Chronic fatigue					
Fainting, POTS					
Fibromyalgia					
Anorexia nervosa					
Other eating disorder (eg bulimia)					
Any autoimmune illness					
Thyroid disorder (Hypo/hyper)					
Arthritis: joint pain, swelling, Stiffness, rheumatoid or juvenile arthritis					
Rheumatic fever					
Heart murmur					
Spondyloarthritis/back/ lower back pain					
Lupus					
Dermatomyositis					
Sjogren's					
Scleroderma					
Multiple sclerosis					
Myesthenia gravis					
ITP					

Gullian-Barre Syndrome					
Celiac/gluten intolerance					
Type 1 diabetes					
Ulcerative colitis					
Regional enteritis, Crohn's disease					
Addison's Disease					
Unusual hair loss (alopecia)					
Psoriasis					
Allergies					
Hay fever					
Asthma					
Eczema					
Other sore throats					
Cough/bronchitis					
Staph/ skin infections					
Hospitalized for infection					
Immune deficiency disorder					
IV gamma globulin treatments					
Migraine headaches					

SCHOOL / EDUCATION

Name of school_____

School Contact person_____Phone_____

Grade level_____Ever had to repeat a grade?_____Grade_____Year_____

Performance since onset (circle one):
at previous level, learning but slower, no progress, regression/loss of academic ability.

Home schooling (circle one): none. Yes, because of symptoms. Yes, other reasons. Considering it.

Requires a special education setting or tutoring at school for major subjects because of symptoms: Y / N