

Last Name	First Name	DOB	Age	Date

FAMILY AND INSURANCE INFORMATION

Patient's Name	Date of Birth	Age	Social Security #	Male / Female

Father's Name	Date of Birth	Social Security #	Married / Single

Address	City	Zip Code	Phone

E-mail Address	Cell Phone

Mother's Name	Date of Birth	Social Security #	Married / Single

Address	City	State	Zip Code	Phone

E-mail Address	Cell Phone

Father's Employer	Address	Phone

Mother's Employer	Address	Phone

Emergency Contact	Phone	Relationship

Who referred you to our office?

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Assignment of Benefits: I authorize the payment of Medical benefits to Vinaya K. Gavini, M.D. for the professional services rendered to my children. I understand that I am financially responsible for all the charges for services rendered to my child by Vinaya K. Gavini, M.D. including the balance remaining after the payment of possible insurance benefits.

“No-show” policy: If you fail to cancel and fail to show up for the appointment, we may charge your account \$20 “no-show” charge. I am aware of this policy and agree to pay such charges.

Signature of Parent or Guardian

Date

Last Name	First Name	DOB	Age	Date

Parent Questionnaire

1. Briefly describe the purpose of today's visit:

- | | |
|---|-----------------------|
| 2. When did symptoms start? | Date _____ |
| 3. On a scale of 0-10 (10 being the worse) rate your child's symptoms | Rating _____ |
| 4. Have your child's teachers complained about your child? | Yes _____ No _____ |
| 5. Have your family and/or friends complained about your child? | Yes _____ No _____ |
| 6. Have you lived in a home built before 1960? | Yes _____ No _____ |
| 7. How has your child's school performance been in the last year? | Good _____ Poor _____ |

DSM-IV QUESTIONNAIRE

(Please check all applicable boxes)

- Some symptoms of hyperactivity-impulsivity or inattention present before age 7
- Some impairment observed in at least 2 settings (e.g., school and home)
- Clear evidence of interference with social, academic, or work function
- No other mental disorders present (e.g., mood, anxiety, dissociative or personality disorder)

Symptoms of inattention

- Often fails to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty maintaining focus on tasks or play activity
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or other responsibilities (not due to oppositional behavior or failure to understand instructions)
- Often has difficulty organizing tasks and activities
- Often avoids, dislikes, or is reluctant to take part in activities that require continuous mental effort, such as schoolwork or homework
- Often loses things needed for tasks or activities, such as toys, assignments, books, or tools
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

_____ **Total**

Symptoms of hyperactivity

- Often fidgets with hands, feet, or squirms in seat
- Often runs around or climbs excessively in situations in which it is not appropriate
- Often leaves seat in classroom or in other situations in which staying seated is expected
- Often has difficulty playing or engaging in leisure activities quietly
- Is often "on the go" or often acts as if "driven by a motor"
- Often talks excessively

Symptoms of impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty waiting for turn
- Often interrupts or intrudes on others (e.g., butting into conversations or games)

_____ **Total**

6 or more symptoms of inattention and/or 6 or more symptoms of hyperactivity-impulsivity YES NO

Last Name	First Name	DOB	Age	Date

Teacher ADHD Questionnaire

DSM-IV QUESTIONNAIRE

(Please check all applicable boxes)

- Some symptoms of hyperactivity-impulsivity or inattention present before age 7
- Some impairment observed in at least 2 settings (e.g., school and home)
- Clear evidence of interference with social, academic, or work function
- No other mental disorders present (e.g., mood, anxiety, dissociative or personality disorder)

Symptoms of inattention

- Often fails to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty maintaining focus on tasks or play activity
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or other responsibilities (not due to oppositional behavior or failure to understand instructions)
- Often has difficulty organizing tasks and activities
- Often avoids, dislikes, or is reluctant to take part in activities that require continuous mental effort, such as schoolwork or homework
- Often loses things needed for tasks or activities, such as toys, assignments, books, or tools
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

_____ **Total**

Symptoms of hyperactivity

- Often fidgets with hands, feet, or squirms in seat
- Often runs around or climbs excessively in situations in which it is not appropriate
- Often leaves seat in classroom or in other situations in which staying seated is expected
- Often has difficulty playing or engaging in leisure activities quietly
- Is often "on the go" or often acts as if "driven by a motor"
- Often talks excessively

Symptoms of impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty waiting for turn
- Often interrupts or intrudes on others (e.g., butting into conversations or games)

_____ **Total**

6 or more symptoms of inattention and/or 6 or more symptoms of hyperactivity-impulsivity YES NO

MA Initials _____

NEW PATIENT QUESTIONNAIRE

Instructions: Please fill out as completely as possible. All information will be kept confidential.

HEALTH CARE STATUS

Is your child under treatment for any illness / condition?	N	Y
Has your child had any allergic reactions to Food or bee stings? Please List:	<input type="checkbox"/> N	<input type="checkbox"/> Y
Has your child had reactions to any immunizations? Please list:	<input type="checkbox"/> N	<input type="checkbox"/> Y
Has your child had any hospitalizations other than Please list:	<input type="checkbox"/> N	<input type="checkbox"/> Y

Please list any medical problems:

List the medications your child is taking now:

List Developmental & Behavior Problems:

FAMILY HISTORY

Please list any blood relatives who have had the following illnesses.

Illness	Relative
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Blood Disease	
Epilepsy	
Asthma/Allergies	
Tuberculosis	
Other	

List any other problems

Please list the general health, age, and sex of parents, brothers, and sisters.

Name	General Health	Age

Have any of your children died? N Y

If Yes, Please Explain:

***If you have a copy of the child's immunization please include it with this form.**

Name of person completing the form: _____

Relationship: _____ Date: _____ Signature: _____

Height	BP	Right	Hearing Test	Vision Test	Allergies
			N	A	
Weight	Temp.	Left	N	A	

PHYSICAL EXAM DESCRIPTION	DESCRIPTION
Head: symmetry, fontanelle	N A

External Eye: EOM; PERLA, conjunctivae; sclerae, exophthalmos; eyelids; photophobia	N	A
Internal Eye: discs; vessels; hemorrhages; lens	N	A
Ear: canals; tympanic membranes; tragus;pinnae	N	A
Nose: septum; mucosa	N	A
Mouth: breath; lips; buccal mucosa; tongue; teeth; palate; pharynx	N	A
Neck: thyroid size, consistency, contour; tracheal position; masses	N	A
Lymph Nodes: cervical, axillary, inguinal, etc.	N	A
Breasts: tenderness; masses; discharge		
Chest/Lungs: deformity; expansion; bone tenderness; dullness; rales; breath sounds; wheezes	N	A
Cardiovascular: S ₁ , S ₂ ; murmurs; pulses	N	A
Abdomen: tenderness; organomegaly; masses; hernias; bowel sounds	N	A
Back: deformity; tenderness	N	A
Genitalia: d/c; masses; tenderness; testis	N	A
Extremities: joint ROM, pain, tenderness	N	A
Neurological: activity; alertness; meningeal signs; gait; DTRs	N	A
Skin: color; texture; lesions; scars	N	A

ADHD MANAGEMENT (Please check off appropriate boxes)

- ADHD Information booklets were given.
- Web site address **adhdclinic.com** given.
- Counseling about family response to the condition given.
- Discussed interpersonal relationships within the family.
- Discussed enhanced safety (riding bikes, crossing streets).
- Discussed how to improve child's self-esteem.
- Stimulant medications discussed.
- Behavior therapy discussed.
- Parents instructed to see me with their child whenever a change of medication is done and also once every three months.
- Parents instructed to come in person to pick up Rx once a month.
- Adverse side effects of medications were discussed.

MA Initials _____

Medication	
Labs	<input type="checkbox"/> Blood Lead Level <input type="checkbox"/> CBC with diff <input type="checkbox"/> Chem 18 <input type="checkbox"/> Lipid Profile <input type="checkbox"/> TSH & T4 <input type="checkbox"/> U/A <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>

Next visit _____

Physician Signature _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization

Signature of Patient or Representative

Date

If Representative, Print Name and Relationship

Date