The LD-ADHD Center of Hawaii, LLC
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RETURNING PATIENT REGISTRATION AND HISTORY: *ADULT*

Date: _____ Which office would you like:

	Pearl City, Oahu
	Honolulu, Oahu
	Hilo, Hawaii

Name: _____ Other names used: _____

DOB: _____ Gender: ___ M or ___ F Marital Status: _____

Address: _____
(Street) *(City)* *(Zip)*

Phone: Home: _____ Cell: _____ Other: _____

Email Address: _____

Medical/psychological diagnosis, physician, and date (if any):

1) _____ 3) _____

2) _____ 4) _____

Briefly describe the problems or symptoms and when they began: _____

_____

What specific questions would you like answered?

1) _____

2) _____

3) _____

Health Insurance: _____ Subscriber Name: _____

Subscriber ID #:_____ Subscriber DOB: _____

This form was completed by: Patient: ___Y or ___N Other: _____
If not completed by the patient, please provide the following information:

Name: _____ Address: _____

Phone: _____ Relation: _____

SYMPTOM SURVEY
Please place a check on the line next to each applicable symptom since the last evaluation at the LD-ADHD Center of Hawaii.

Problem Solving

_____ Difficulty figuring out how to do new things

_____ Difficulty planning ahead

_____ Difficulty figuring out problems that most other people can do

_____ Difficulty thinking as quickly as needed

_____ Difficulty doing things in the right order

_____ Difficulty verbally describing the steps involved in doing something

_____ Difficulty changing a plan or activity when necessary

_____ Difficulty completing an activity in a reasonable amount of time

_____ Difficulty doing more than one thing at a time

_____ Difficulty switching from one activity to another activity

_____ Easily frustrated

_____ Other problem solving difficulties: _____

Speech, Language and Math Skills

_____ Difficulty finding the right words to say

_____ Difficulty understanding what others are saying

_____ Unable to speak

_____ Difficulty staying with one idea

_____ Difficulty writing letters or words (not due to motor problems)

_____ Slurred speech

_____ Odd or unusual speech sound

_____ Difficulty with math (checkbook balancing, making change, etc.)

_____ Difficulty understanding what was read

_____ Difficulty spelling

_____ Other speech, language, or math problems: _____

Nonverbal Skills

_____ Difficulty telling right from left

_____ Difficulty doing things that I should automatically be able to do (brushing teeth, etc.)

_____ Problems drawing or copying

_____ Difficulty dressing (not due to physical difficulty)

_____ Problems finding my way around places I've been to before

_____ Difficulty recognizing objects or people

_____ Parts of my body do not seem as if they belong to me

_____ Unaware of things on one side of my body (right _____/left _____)

_____ Decline in my musical abilities

_____ Slow reaction time

_____ Other nonverbal issues: _____

Concentration and Awareness

_____ Highly distractible

_____ Lose my train of thought easily

_____ Problems concentrating

_____ Become easily confused or disoriented

_____ Blackout spells (fainting)

_____ My mind goes blank

_____ Don't feel very alert or aware of things

_____ Other concentration or awareness issues: _____

Memory

_____ Forgetting where I leave things (keys, books, etc.)

_____ Forgetting names

_____ Forgetting what I should be doing

_____ Forgetting where I am or where I am going

_____ Forgetting events that happened quite recently (such as my last meal)

_____ Forgetting events that happened a long time ago (months/years)

_____ Need someone to give me a hint so I can remember things

_____ Forgetting the order of things (when cooking, etc.)

_____ Forgetting facts but I can remember how to do things

_____ Forgetting how to do things but I can remember facts

_____ Forgetting faces of people I know (when they are not present)

_____ Frequently forgetting appointments

_____ Other memory issues: _____

Motor Coordination

		Right	*Left*	*Both*
_____	Fine motor control problems	_____	_____	_____
_____	Weakness on one side of my body	_____	_____	_____
_____	Difficulty walking or bumping into things	_____	_____	_____
_____	Tremor or weakness	_____	_____	_____
_____	Muscle tics or strange movements	_____	_____	_____

_____ My writing is very small

_____ My writing is very large

_____ Walking more slowly than other people

_____ Feeling stiff

_____ Balance problems

_____ Difficulty starting to move

_____ Jerky muscles

_____ Muscles tire quickly

_____ Often bumping into things

_____ Other motor or coordination issues: _____

Sensory

_____ Loss of feeling or numbness

_____ Tingling or strange skin sensations

_____ Difficulty telling hot from cold

_____ Problems seeing on one side

_____ Blurred vision

_____ Blank spots in vision

_____ Brief periods of blindness

_____ See "stars" or flashes of light

_____ Double vision

_____ Difficulty looking quickly from one objects to another object

_____ Need to squint or move closer to see clearly

_____ Losing hearing

_____ Ringing in my ears or hearing strange sounds

_____ Difficulty tasting food

_____ Difficulty smelling

_____ Smelling strange odors

_____ Other sensory issues: _____

Physical

_____ Headaches

_____ Dizziness

_____ Nausea or vomiting

_____ Urinary incontinence

_____ Loss of bowel control

_____ Excessive tiredness

_____ Other physical issues: _____

Behavior

Check all that apply to you in the past 6 months: Severity Level: *Mild* *Moderate* *Severe*

_____ Sadness or depression _____ _____ _____

_____ Anxiety or nervousness _____ _____ _____

_____ Sleeping issues (Falling asleep: ___ Staying asleep: ___) _____ _____ _____

_____ Becoming angry more easily _____ _____ _____

_____ Euphoria (feeling on top of the world)

_____ Much more emotional (cry more easily)

_____ Feel as if I just don't care anymore

_____ Doing things automatically (without awareness)

_____ Less inhibited (do things I would not do before)

_____ Difficulty being spontaneous

_____ Change in eating habits

_____ Change in interest in sex

_____ Other recent changes in behavior/personality: _____

Check the answer that best fits.

Overall, my symptoms have developed: ___ Slowly ___ Quickly

My symptoms occur: ___ Occasionally ___ Often

Over the past 6 months my symptoms have: ___ Stayed the same ___ Worsened

List any medications you currently take (prescription or over the counter):

Medication	Dosage	Frequency Taken	Date began Taking	Prescribed by	Prescribed for

Describe all hospitalizations (include purpose, length of stay, and location): _____

_____

_____

Medical Informaiton

Who is your primary care physician:

Name: _____ Clinic: _____

Address: _____ Phone: _____

Do you have a treating psychologist/psychiatrist?

Name: _____ Clinic: _____

Address: _____ Phone: _____

Start date of therapy: _____ Frequency of therapy: _____

Reason for therapy: _____

Have you had a previous psychological/neuropsychological evaluation? ___ Yes ___ No

If yes, please list the name and address of the psychologist and date administered:

_____

* Please provide a copy of the report at your intake appointment

Medical Testing

Check all the medical tests that recently (within the past year) have been done and report any abnormal findings:

Please also state the name of the physician who ordered or did the test for you.

___ Angiography _____

___ Blood Work _____

___ CT scan _____

___ EEG _____

___ MRI/FMRI _____

___ PET/SPECT scan _____

___ Other test(s) _____

Personal History

Occupational History

Current job title: _____ How long at job? _____

Current job responsibilities: _____

Prior jobs and time spent at them: _____

_____

At any time on a job, were you exposed to toxic, hazardous, noxious or other dangerous or unusual substances? (ex. Lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?

___ Yes ___ No If yes, list: _____

Substance Use History

Alcohol

I drink alcohol: ___ Rarely or never ___ 3-5 days per week

___ 1-2 days per week ___ Daily

I use drink but stopped (date stopped): _____

I started drinking regularly at age: ___ Preferred type of drinks: _____

My last drink was: ___ less than 24 hours ago ___ 24-48 hours ago ___ over 48 hours ago

Check all that apply:

___ I can drink more than most people my age and size before I feel drunk

___ I sometimes get into trouble after drinking

___ I sometimes blackout during or after drinking

Drugs

Please check all drugs you are currently using or have used in the past:

	Presently using	*Used in the past*
___ Amphetamines	___	___
___ Barbiturates	___	___
___ Cocaine or crack	___	___
___ Hallucinogens	___	___
___ Marijuana	___	___
___ Opiates/Narcotics (Heroin)	___	___
___ PCP	___	___

List any other drugs, including designer and “non-harmful” of “non-addictive” drugs: _____

_____

Do you consider yourself dependent on any of the above drug(s)? ___ Yes ___ No

Do you think you are dependent on any prescription drug(s)? ___ Yes ___ No

Check all that apply:

___ I have gone though drug withdrawal

___ I have used IV drugs

___ I have been in drug treatment