



San Diego

ADHD & LEARNING CLINIC

PATIENT INTAKE FORM

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If this is for a minor, please have the parent or legal guardian complete this form.

Thank you for choosing San Diego ADHD & Learning Clinic. The information you provide helps us understand your background and concerns so we can conduct a thorough and individualized evaluation.

PRIVACY NOTICE
All information you provide is confidential and will only be used for the purpose of evaluation and treatment planning. We use HIPAA-compliant systems and technology.

OFFICE USE ONLY
Date Received: _____ MRN: _____
Appointment Date(s): _____

1 1. DEMOGRAPHIC INFORMATION

1.1 Patient Information

Full Name: _____

Preferred Name (if different): _____

Date of Birth: _____ Age: _____

Gender: Male Female Non-binary Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Preferred Contact Method: Phone Email Text Mail

Primary Language: _____

Other Languages Spoken: _____

Marital Status: Single Married Partnered Divorced
 Separated Widowed

Ethnicity: _____ Race (optional): _____

Emergency Contact Name: _____

Relationship to Patient: _____

Phone: _____

1.2 Parent / Guardian Information (if applicable)

Parent/Guardian Name(s): _____

Relationship to Patient: _____

Phone: _____ Email: _____

Address (if different from above): _____

? 2. REASON FOR EVALUATION

What is the main reason(s) you (or your child) are seeking an evaluation?

! 3. CURRENT CONCERNS

Please describe the specific concerns you or others have noticed. Include examples and when these concerns began.

■ 4. INFORMATION SOURCES

Who is completing this form?

- Patient Parent/Guardian Other: _____

Other individuals involved in the patient's care (therapist, teacher, doctor, etc.):

How did you hear about our clinic?

- Physician/Healthcare Provider School Family/Friend
 Internet Search Insurance Directory Other: _____

+ 5. MEDICAL HISTORY

5.1 Primary Care Information

Primary Care Physician: _____

Physician Phone: _____

5.2 Current Medical Conditions

Please list any current medical conditions (e.g., asthma, diabetes, seizures):

5.3 Past Medical Conditions / Surgeries / Hospitalizations

5.4 Current Medications

Please list all current medications (name, dose, reason):

5.5 Allergies

No Known Allergies

If yes, please list: _____

5.6 Sleep

Bedtime: _____ Wake Time: _____

Hours per night: _____

Sleep Quality:

Good Fair Poor

5.7 Appetite

Appetite:

Good Fair Poor

6. DEVELOPMENTAL HISTORY

6.1 Pregnancy / Birth

Were there any complications during pregnancy or birth?

Yes No If yes, please describe: _____

6.2 Developmental Milestones

Please indicate if the following occurred on time, late, or early.

	On Time	Late	Early	N/A
Sat up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combined words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet trained (day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet trained (night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.3 Early Intervention Services

Did the patient receive any early intervention services (e.g., speech, OT, PT)?

Yes No If yes, please describe: _____

7. ACADEMIC HISTORY

Current School / Grade (or Highest Completed): _____

School District / Name: _____

Academic Setting: General Education 504 Plan IEP Other: _____

Current Academic Concerns: _____

Grade Retention: Yes No If yes, grade(s): _____

History of Learning Support / Tutoring: Yes No If yes, please describe: _____

8. EMPLOYMENT HISTORY (if applicable)

Current Employment Status: Employed Full-Time Employed Part-Time Unemployed Student Other: _____

Occupation / Job Title: _____

Employer: _____ Start Date: _____

Work Concerns / Challenges (if any): _____

9. STRENGTHS & WEAKNESSES

What are your (or your child's) strengths?

What are your (or your child's) areas of difficulty or weaknesses?

10. ADDITIONAL INFORMATION

Is there any other information you feel would be important for us to know?

