

MEDICAL EVALUATION ADULT WORK/SCHOOL PROGRESS

BROOKLYN PARK OFFICE
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MAPLE GROVE OFFICE
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12720 Bass Lake Road
Maple Grove MN 55369
(763) 559-2861
FAX (612) 874-2902

PLYMOUTH OFFICE
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2855 Campus Drive, #350
Plymouth MN 55441
(763) 520-1200
FAX (612) 874-2908

ROGERS OFFICE
13980 Northdale Boulevard
Rogers MN 55374
(763) 428-1920
FAX (612) 874-2916

Thank you for choosing Partners in Pediatrics for your medical evaluation for attention and school/work difficulties. We are committed to performing this evaluation in the comprehensive manner that each patient deserves. The evaluation and treatment options available often involve long-term strategies, and it is more important to do this carefully than to do it quickly. We realize that waiting may be difficult, but please be patient as we arrange the evaluation process.

The evaluation consists of a 40 minute visit. We will review the historical and behavioral information with you. You may also bring a parent or significant other. At the completion of the visit, your provider will discuss with you the diagnosis and treatment plans. There may be more questionnaires to complete and possibly a computer-based evaluation test.

Please find enclosed separate questionnaires. These forms are used to gather historical and diagnostic information necessary for the evaluation. Please fill out the entire packet. If you have misplaced the forms, you can go to our website www.pipstop.com to print them. Please obtain copies of any previous school or private psychological evaluations and a recent report card, if available.

We will contact you to schedule your appointments after we have received the completed forms. Please return them in the enclosed envelope as soon as they are completed.

Services for this evaluation may be covered under your health plan. Some plans may provide a different level of benefit for evaluations such as these, placing them under mental health rather than medical benefits. **Please contact your insurance company directly about this coverage prior to your evaluation.** You may contact our business office to discuss payment arrangements.

Please contact your office if you have any problems.

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**MEDICAL HISTORY FORM
ADULT WORK/SCHOOL PROGRESS EVALUATION
(Parent may help complete if desired)**

Date form filled out: _____

Your Name: _____ Birthdate: _____

Primary Phone: _____ Secondary Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

School/Other Address: _____

City: _____ State: _____ Zip: _____

Best Address and Phone number to reach you at: _____

Name of School/Work: _____ Year Expected Graduation: _____

Referred by: _____

Your private physician: _____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

<u>Date</u>	<u>Name of physician, psychologist, agency, or clinic</u>
_____	_____
_____	_____
_____	_____

Please list the problems with which you want help for yourself:

1. _____
2. _____
3. _____
4. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

Name: _____ Date of Birth: _____

EDUCATIONAL SITUATION/JOB STATUS

Please describe your current classroom placement and services (attach copies of any school psycho-educational reports if available):

School performance: What has your school/employer told you about the following:

Behavior? _____

Work completion? _____

Academic progress? _____

Handwriting/neatness: _____

Please describe previous school problems:

<u>Grade/year</u>	<u>School/Center name</u>	<u>Problems</u>

Please describe previous work problems:

<u>Employer name</u>	<u>Problems</u>

HOME/FAMILY

1. Briefly describe any behavior or family issues that bother you:

2. Please describe any conflict surrounding homework/work/studying: _____

Name: _____ Date of Birth: _____

SOCIAL

1. How many close friends do you have? _____
2. Describe any problems you may have in making and keeping friends: _____

3. Please describe any aspect of your social life that bothers you: _____

SELF-ESTEEM

How do you feel these problems are affecting your self-esteem? _____

PAST MEDICAL HISTORY

Were there any problems when your mother was pregnant with you? Yes No
 If yes, describe: (ex. Low birth weight) _____

Were there any problems during your newborn period? Yes No

GROWTH / NUTRITION

Have you had any problems with: (if Yes, please describe)

- Growth in height: No Yes: _____
- Weight loss or gain: No Yes: _____

Additional details or comments: _____

DEVELOPMENT

Was your development normal compared to other children? Yes No Describe:
 Age you first walked _____
 Age you spoke your first word _____

Are your immunizations up-to-date? Yes No
 (Please include a copy of current immunization records)

Describe any serious reactions: _____

Name: _____ Date of Birth: _____

List any known allergies to medications, foods, pollens, or inhalants: _____

Describe any hospitalizations or surgery (date, reason, problems): _____

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): _____

SOCIAL HISTORY

Family member/name

Years of school

Occupation

Father: _____

Mother: _____

Stepfather: _____

Stepmother: _____

Parents are: married separated divorced never married

Please share any history of significant (if any) marital problems: _____

I am in a relationship married separated divorced never married not in a relationship

Where do you live and with whom? _____

BEHAVIOR HISTORY:

If the patient has experienced any of these behavior problems, please record the ages they occurred:

BEHAVIOR	NO	YES	AGES
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Explain any behavior problems listed above:

Name: _____ Date of Birth: _____

FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family *other than yourself* may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

FAMILY HISTORY	Your mother	Your father	Your brother(s)	Your sister(s)	Others (Specify)
LEARNING					
Difficulty learning to read					
Difficulty with arithmetic					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Mental retardation					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
Heart attach/stroke before age 55					
Sudden/unexplained deaths before age 40					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

Father's age: _____

Mother's age: _____

Sister(s) names and ages: _____

Brother(s) names and ages: _____

Name: _____ Date of Birth: _____

FAMILY HEART HISTORY:

If a member of your family has had any of these medical problems, please record their relationship to you.

PROBLEM	NO	YES	RELATIONSHIP
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

PERSONAL HEART HISTORY:

If you have experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

REVIEW OF SYSTEMS

Please list currently prescribed or over-the-counter medications taken and their doses:

_____	_____
_____	_____
_____	_____

Name: _____ Date of Birth: _____

If you have experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Heart murmur			
Irregular heart beat or palpitations			
Fainting			
Chest pain			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods – age at onset _____ Problems?			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other:			

SCHOOL (WORK) EVALUATION INITIAL SELF REPORT

Name: _____ Date of Birth: _____

Today's Date: _____ Your Phone Number: _____

- Please summarize your main concerns: _____

- When did these difficulties begin? _____
- How has this affected your schoolwork and/or job? _____

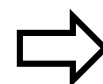
- How has this affected your relationship with your family? _____

- How has this affected your relationship with your friends, classmates, team members, or coworkers?

- Have you been on medication for ADHD, Depression, Anxiety, or Mental Health in the past? Yes No
If yes, when and how treated? _____

Directions: When completing this form, please think about your behaviors in the past 6 months.

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. I do not pay attention to details or make careless mistakes with, for example, homework or other work.	0	1	2	3
2. I have difficulty keeping attention to what needs to be done.	0	1	2	3
3. I do not seem to listen well when spoken to directly.	0	1	2	3
4. I do not follow through when given directions and fail to finish activities.	0	1	2	3
5. I have difficulty organizing tasks and activities.	0	1	2	3
6. I avoid, dislike, or do not want to start tasks that require ongoing mental effort.	0	1	2	3
7. I lose things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. I am easily distracted by noises or other stimuli.	0	1	2	3
9. I am forgetful in daily activities.	0	1	2	3
10. I fidget and squirm a lot.	0	1	2	3
11. I have trouble remaining seated when it is expected.	0	1	2	3
12. I am restless and agitated	0	1	2	3
13. I have trouble engaging in leisurely activities quietly.	0	1	2	3
14. I am "on the go" and have a hard time relaxing.	0	1	2	3
15. I talk too much.	0	1	2	3
16. I blurt out answers before questions have been completed.	0	1	2	3
17. I have difficulty waiting my turn in conversations, activities or driving.	0	1	2	3
18. I interrupt or intrude in on others' conversations and/or activities.	0	1	2	3



Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
19. I argue with others often.	0	1	2	3
20. I lose my temper easily.	0	1	2	3
21. I actively defy or refuse to go along with others' requests and/or activities.	0	1	2	3
22. I blame others for my mistakes or misbehavior.	0	1	2	3
23. I am touchy or easily annoyed by others.	0	1	2	3
24. I am angry or resentful.	0	1	2	3
25. I am spiteful and want to get even.	0	1	2	3
26. I have bullied, threatened, or intimidated others.	0	1	2	3
27. I start physical fights.	0	1	2	3
28. I lie to get out of trouble or to avoid obligations.	0	1	2	3
29. I am physically cruel to people.	0	1	2	3
30. I have stolen things that have value.	0	1	2	3
31. I have deliberately destroyed others' property.	0	1	2	3
32. I have used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
33. I have been physically cruel to animals.	0	1	2	3
34. I have deliberately set fires to cause damage.	0	1	2	3
35. I have broken into someone else's home, business, or car.	0	1	2	3
36. I have stayed out at night without informing others of my whereabouts.	0	1	2	3
37. I have left home overnight without warning.	0	1	2	3
38. I have forced someone into sexual activity.	0	1	2	3
39. I am fearful, anxious, or worried.	0	1	2	3
40. I am afraid to try new things for fear of making mistakes.	0	1	2	3
41. I feel worthless or inferior.	0	1	2	3
42. I blame myself for problems, feel guilty.	0	1	2	3
43. I feel lonely, unwanted, or unloved; complain that "no one loves me".	0	1	2	3
44. I am sad, unhappy, or depressed.	0	1	2	3
45. I am self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
46. Overall school/work performance	1	2	3	4	5
47. Reading	1	2	3	4	5
48. Math	1	2	3	4	5
49. Writing	1	2	3	4	5
50. Relationships with parents.	1	2	3	4	5
51. Relationships with siblings.	1	2	3	4	5
52. Relationships with peers.	1	2	3	4	5
53. Relationship with spouse/significant other	1	2	3	4	5

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS**

<input type="checkbox"/> Brooklyn Park office 8500 Edinbrook Parkway Brooklyn Park MN 55443 Phone: 763-425-1211 Fax: 612-874-2907	<input type="checkbox"/> Calhoun office 3910 Excelsior Blvd St Louis Park, MN 5416 Phone: 952-562-8787 Fax: 612-874-2909	<input type="checkbox"/> Maple Grove office 12720 Bass Lake Road Maple Grove MN 55369 Phone: 763-559-2861 Fax: 612-874-2902	<input type="checkbox"/> Plymouth office 2855 Campus Drive, #350 Plymouth MN 55441 Phone: 763-520-1200 Fax: 612-874-2908	<input type="checkbox"/> Rogers office 13980 Northdale Blvd Rogers MN 55374 Phone: 763-428-1920 Fax: 612-874-2916
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Provider Initials: _____

PARENT or SIGNIFICANT OTHER REPORT ADULT WORK/SCHOOL PROGRESS

Today's Date: _____ Name: _____ Date of Birth: _____

Parent/Significant Other Name: _____ Patient's Phone Number: _____

Directions: When completing this form, please think about the patient's behaviors in the past 6 months.

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Does not pay attention to details or makes careless mistakes with, for example, homework or other work.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms a lot.	0	1	2	3
11. Has trouble remaining seated when it is expected.	0	1	2	3
12. Is Agitated and restless	0	1	2	3
13. Has difficulty engaging in leisurely activities quietly.	0	1	2	3
14. Is "on the go" and has a hard time relaxing	0	1	2	3
15. Talks too much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn in conversations, activities, or driving.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues often.	0	1	2	3
20. Loses temper easily.	0	1	2	3
21. Actively defies or refuses to go along with others' requests and/or activities.	0	1	2	3
22. Blames others for his or her mistakes or misbehavior.	0	1	2	3
23. Is touchy or easily annoyed by others.	0	1	2	3
24. Is angry or resentful.	0	1	2	3
25. Is spiteful and wants to get even.	0	1	2	3
26. Bullies, threatens, or intimidates others.	0	1	2	3
27. Starts physical fights.	0	1	2	3
28. Lies to get out of trouble or to avoid obligations (i.e. "cons" others).	0	1	2	3
29. Is physically cruel to people.	0	1	2	3
30. Has stolen things that have value.	0	1	2	3
31. Deliberately destroys others' property.	0	1	2	3
32. Has used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
33. Is physically cruel to animals.	0	1	2	3
34. Has deliberately set fires to cause damage.	0	1	2	3
35. Has broken into someone else's home, business, or car.	0	1	2	3
36. Has stayed out at night without informing others.	0	1	2	3
37. Has left home overnight without warning.	0	1	2	3
38. Has forced someone into sexual activity.	0	1	2	3



Continued on Reverse

Patient's Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
39. Is fearful, anxious, or worried.	0	1	2	3
40. Is afraid to try new things for fear of making mistakes.	0	1	2	3
41. Feels worthless or inferior.	0	1	2	3
42. Blames self for problems, feels guilty.	0	1	2	3
43. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
44. Is sad, unhappy, or depressed.	0	1	2	3
45. Is self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
46. Overall school/work performance	1	2	3	4	5
47. Reading	1	2	3	4	5
48. Math	1	2	3	4	5
49. Writing	1	2	3	4	5
50. Relationships with parents.	1	2	3	4	5
51. Relationships with siblings.	1	2	3	4	5
52. Relationships with peers.	1	2	3	4	5
53. Relationship with spouse/significant other	1	2	3	4	5

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