ADVANCED PEDIATRIC ASSOCIATES
Hand in Hand for Healthy Kids

Greetings from the Providers at Advanced Pediatric Associates:

Attention Deficit Hyperactivity Disorder (ADHD) / Attention Deficit Disorder (ADD) is challenging for individuals. ADHD is a common chronic illness in the United States with a prevalence thought to be around 6% of the population.

When managed appropriately, medication and regularly scheduled follow-up appointments for ADHD can control symptoms of hyperactivity, impulsiveness, and lack of focus and concentration. To ensure that treatment is managed correctly, it is important that patients be monitored closely by a healthcare provider.

To ensure we are following American Academy of Pediatrics (AAP) guidelines, some of our processes and procedures are:

- Follow-up appointments are required every three months.
- Follow-up paperwork is required every six months.
- Medication refills will be managed at follow-up appointments.
- It is important to complete the needed paperwork and make your follow-up appointments before medication runs out.
- Our ADHD coordinator will contact you to aid in scheduling follow-up appointments.
- Telehealth **may** be offered for these follow-up appointments up to two times a year and at the discretion of the provider.
- Annual well care **may** be combined with a follow-up visit. You must be stable on your current dosage of ADHD medication, and a combined visit must be approved by your provider.

Enclosed please find forms for you to complete. Please return the questionnaires to us by fax, email, or drop them off at a clinical office.

- Fax: 720-974-7189
- Email: apa.ref@advanced-pediatrics.com
- Clinical office locations:
    - 5657 S. Himalaya St., #100, Centennial, CO 80015
    - 1300 S. Potomac St., #156, Aurora, CO 80012
    - 9397 Crown Crest Blvd., #330, Alpine Building, Parker, CO 80138

After the forms have been received and reviewed by the provider, we will contact you to schedule an appointment for a medication evaluation.

Additional charges will be added to the next office visit for the provider's time to score and evaluate the questionnaires.

We look forward to working with you under these new guidelines. Please contact our ADHD coordinators at 720-974-7188 with any questions.

Enclosures

APA ADD420 6/2024

Aurora Office
1300 S. Potomac Street, Suite 156 | Aurora, CO 80012

Centennial Office
5657 S. Himalaya Street, Suite 100 | Centennial, CO 80015

Parker Office
9397 Crown Crest Boulevard, Suite 330 | Parker, CO 80138

Administrative Office
3300 S. Parker Road, Suite 404 | Aurora, CO 80014

Phone | 303-699-6200 Fax | 303-766-6903

ADVANCED PEDIATRIC ASSOCIATES
Hand in Hand for Healthy Kids

ADHD ADULT (17+) INITIAL QUESTIONNAIRE 1/3

Patient Name: _____ DOB: _____ Age: _____Today's Date: _____

1. Do you have a preferred provider? ☐ No Preference ☐ Yes_____
2. In your own words, what is the reason for this evaluation? _____
3. When did you first notice these concerns? _____
4. As a child did you have any developmental delays or concerns?

   _____

   _____
5. Did you receive special services at school? (Examples: educational plan (IEP, 504), support from a tutor)

   _____

   _____

   _____
6. Have you met with a professional to support your behavioral or emotional health? (Example: therapist, psychologist, psychiatrist, or social worker)

   _____

   _____

   _____

MEDICAL HISTORY

1. Are you currently or have you previously taken medications or supplements regularly?

Medication/Supplement	Dosage	Medication/Supplement	Dosage

2. Do you have a history of significant or chronic medical problems? (Example: history of heart problems, palpitations, fainting, or seizures.) _____

   _____

SLEEP HISTORY

1. Do you have any concerns regarding your sleep?

   _____

   _____

ADVANCED PEDIATRIC ASSOCIATES

Hand in Hand for Healthy Kids

ADHD ADULT (17+) INITIAL QUESTIONNAIRE 2/3

SCHOOL & WORK SKILLS

1. How do you feel about school and/or work?

   _____

2. Are there any subjects or tasks that you particularly like or dislike?

   _____

3. Do your teachers or employers have any concerns about your performance?

   _____

SOCIAL HISTORY

4. Who do you live with?

   _____

5. Do you struggle with making and keeping friends?

   _____

   _____

6. Have you or your family recently or previously faced stressful circumstances that may be affecting you?

   (Example: divorce, financial hardship, death, illness, abuse, or changes at home)

   _____

   _____

7. Is there anything else we should know about you or your family?

   _____

   _____

FAMILY HISTORY

Please indicate any relatives with any of the following:

	Siblings	Biological Mother	Mother's Relative	Biological Father	Father's Relatives
ADHD	☐	☐	☐	☐	☐
Obsessive-Compulsive Disorder, fussy habits, picky, rigid	☐	☐	☐	☐	☐
Tics or other nervous habits, Tourette syndrome	☐	☐	☐	☐	☐
Depression for more than 2 weeks, medications for mood disorder	☐	☐	☐	☐	☐
Suicide or attempted suicide	☐	☐	☐	☐	☐
Psychosis or schizophrenia, hospitalized for mental or emotional issues	☐	☐	☐	☐	☐
Alcohol or drug abuse	☐	☐	☐	☐	☐
Legal problems, arrests, jail/prison time, court probations, "always in trouble"	☐	☐	☐	☐	☐
Serious or chronic medical conditions: heart problems, seizures, diabetes, etc.	☐	☐	☐	☐	☐
Gambling, shopping, or other compulsions	☐	☐	☐	☐	☐
Autism spectrum disorders	☐	☐	☐	☐	☐

ADVANCED PEDIATRIC ASSOCIATES
Hand in Hand for Healthy Kids

ADHD ADULT (17+) INITIAL QUESTIONNAIRE 3/3

SYMPTOM SCREENERS

Please circle the number next to each item that best describes your behavior during the last 6 months.

Items:	Never or Rarely	Sometimes	Often	Very Often
1. Fail to give close attention to details or make careless mistakes in my work	0	1	2	3
2. Have difficulty sustaining my attention in tasks or fun activities	0	1	2	3
3. Don't listen when spoken to directly	0	1	2	3
4. Don't follow through on instructions and fail to finish work	0	1	2	3
5. Have difficulty organizing tasks and activities	0	1	2	3
6. Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort	0	1	2	3
7. Lose things necessary for tasks or activities	0	1	2	3
8. Am easily distracted	0	1	2	3
9. Am forgetful in daily activities	0	1	2	3
10. Fidget with hands or feet or squirm in seat	0	1	2	3
11. Leave my seat in situations in which seating is expected	0	1	2	3
12. Feel restless	0	1	2	3
13. Have difficulty engaging in leisure activities or doing fun things quietly	0	1	2	3
14. Feel "on the go" or "driven by a motor"	0	1	2	3
15. Talk excessively	0	1	2	3
16. Blurt out answers before questions have been completed	0	1	2	3
17. Have difficulty awaiting turn	0	1	2	3
18. Interrupt or intrude on others	0	1	2	3

To what extent do the problems you may have circled interfere with your ability to function in each of these areas?

Areas:	Never or Rarely	Sometimes	Often	Very Often
In my home life and daily responsibilities	0	1	2	3
In my school and educational activities	0	1	2	3
In my work or occupation	0	1	2	3
In my social interactions with others	0	1	2	3
In other activities (e.g. driving, recreational activities)	0	1	2	3

Over the last two weeks, how often have you been bothered by the following problems?

PHQ-4	Not at all	Several Days	More than half the days	Nearly Every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

0	≥1