Attention Disorders Clinic

94 Marshall Drive • Endicott, N.Y. 13760 PHONE (607) 785-0400 FAX (607) 785-0077
www.theADHDdoc.com

Vincent J. Monastra, Ph.D.
Clinical Director

PATIENT'S NAME: _____ Soc. Security: _____

Birth Date: _____

Address: _____ Phone: (H): _____

_____ Work: _____

Email: _____ Cell: _____

Insurance Co: _____

Insurance ID: _____ Policy Holder: _____

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If the patient is a child/adolescent, please complete this section:

Parent's Names: _____

Parent's Address(es): _____

_____

Parent(s) Employers: _____

Child's School: _____ Grade: _____

Child's Physician: _____

Doctor's Address: _____

Child's Medications: _____

Child's Medical Problems _____

Reasons for Seeking Evaluation: _____

_____

SEE OTHER SIDE

If you are an adult seeking evaluation/treatment for yourself, please complete this section:

Employer's Name: _____

Your Position: _____

Your highest educational level: _____

Name of the school where you completed high school: _____

Name of the school where you attended college: _____

Your physician's name: _____

Medications you currently use: _____

Please list any medical problems: _____

Why are you seeking evaluation/treatment at this time? _____

_____

Who did you consult with for this problem before coming to our clinic? _____

_____

Has any member of your family (parents; siblings; grandparents; aunts; uncles; cousins) shown symptoms of any of the following problems (check those that apply):

_____ alcoholism	_____ compulsive gambling	____ sexual addiction
_____ obesity	_____ drug abuse	____ anxiety
_____ depression	_____ frequent loss of temper	_____ panic disorder
_____ ADHD	_____ learning disorders	_____ criminal actions

CLINICAL HISTORY QUESTIONNAIRE

Vincent J. Monastra, Ph.D.

NAME OF PATIENT: _____; BIRTHDATE: _____

INFORMATION PROVIDED BY: _____

RELATIONSHIP TO PATIENT: _____

Over the years, doctors have learned that children, teenagers and adults can develop symptoms of inattention, impulsivity, or restlessness for a variety of reasons. They have also learned that it is rare that these symptoms occur in isolation. Often, patients with these problems will also experience symptoms of anxiety, depression, irritability and have difficulty functioning effectively at home, school, work, and other social settings. The purpose of this questionnaire is to help your doctor or therapist better understand the kinds of problems that you want to overcome, and to begin to determine possible causes for these problems. By answering these questions, you will be providing important information to guide this process.

Take your time in answering, there is no rush. If you do not understand a question, please circle it and your doctor or therapist will discuss it with you. If you have difficulty writing your responses, please let your therapist or doctor know so that they can assist you. Thank you for taking the time to complete this form.

PRIMARY REASON(S) THAT YOU DECIDED TO SEEK A CONSULTATION:

Please check all that apply:

_____ Problems paying attention while listening

_____ Problems paying attention while reading

_____ Problems paying attention while completing homework

_____ Problems paying attention while completing writing tasks at work

_____ Failure to pass subjects at school

_____ Truancy or excessive absence from classes

_____ Problems organizing paperwork

_____ Problems organizing personal belongings

_____ Time management (procrastination; missing deadlines)

_____ Restlessness or hyperactivity

_____ Acting impulsively (without considering the consequences)

_____ Problems controlling anger or temper

_____ Depression

_____ Anxiety

_____ Alcohol or Drug abuse

_____ Difficulty falling or staying asleep

_____ Poor response to medication or medication side effects

_____ Physical and/or psychological trauma

_____ Concerns about diet, weight or food issues

_____ Family conflicts

_____ Other: Please describe: _____

I. AREAS OF CLINICAL CONCERN: Your answers to the following questions will give your doctor or therapist a comprehensive perspective of the types of problems that caused you to seek a consultation.

A. Problems of Attention, Impulsivity & Hyperactivity:

Please circle Y (yes) or N (no) if the problem described is a cause of concern to you:

a. Problems giving close attention to details, careless mistakes in school tasks, work assignments or other activities	Y	N
b. Problems sustaining attention in tasks or play activities	Y	N
c. Problems listening when spoken to directly	Y	N
d. Problems following through on instructions. Failure to complete schoolwork, chores, or duties in the workplace	Y	N
e. Problems organizing tasks and activities	Y	N
f. Problems engaging in tasks that require sustained mental effort (e.g. school work or homework or job assignments) due to avoidance or dislike for the activity	Y	N
g. Problems losing things necessary for tasks or activities	Y	N
h. Problems with distractibility	Y	N
i. Problems with forgetfulness	Y	N
CN = 6		
j. Problems controlling fidgeting with hands or feet; squirming	Y	N
k. Problems leaving seat in classrooms or in other situations in which remaining seated is expected	Y	N
l. Problems controlling an urge to run about or climb excessively in situations in which it is inappropriate. A sense of restlessness (teens and adults)	Y	N
m. Problems playing or engaging in leisure activities quietly	Y	N

n.	Problems associated with excessive activity. Often "on the go" or seems/feels driven by a motor"	Y	N
o.	Problems controlling the urge to talk excessively	Y	N
p.	Problems controlling the urge to blurt out answers before questions have been completed	Y	N
q.	Problems waiting turn	Y	N
r.	Problems controlling the urge to interrupt or intrude on others (e.g. butts into conversations or games)	Y	N

CN = 6

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time? (List by letter):

Have any of these problems gotten worse over the course of time? (List by letter):

B. Problems of Oppositionalism & Defiance:

a.	Problems controlling temper	Y	N
b.	Problems controlling the urge to argue with adults	Y	N
c.	Problems controlling the urge to defy or refuse adults	Y	N
d.	Problems controlling the urge to deliberately do things that annoy other people	Y	N
e.	Problems taking responsibility for own mistakes: tends to blame others	Y	N
f.	Often "touchy" or easily annoyed by others	Y	N
g.	Often angry or resentful	Y	N

h. Often spiteful or vindictive Y N

i. Problems controlling the urge to swear or use obscene language Y N

CN = 4

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time? (list by letter):

Have any of these problems gotten worse over the course of time? (list by letter):

C. Problems of Conduct:

a. Problems controlling the urge to bully, threaten, or intimidate others Y N

b. Problems controlling the urge to initiate physical fights Y N

c. Problems controlling the urge to use a weapon that can cause serious physical harm to others Y N

d. Problems controlling the urge to be physically cruel to others Y N

e. Problems controlling the urge to be physically cruel to animals Y N

f. Problems controlling the urge to steal while confronting the victim Y N

g. Problems controlling the urge to force someone into sexual activity Y N

h. Problems controlling the urge to set fires with the intention of causing serious damage Y N

i. Problems controlling the urge to deliberately destroy another's property (other than by fire) Y N

j. Problems controlling the urge to break into someone else's house, building, or car Y N

k. Problems controlling the urge to lie to obtain goods or favors or to avoid obligations ("cons" others) Y N

l. Problems controlling the urge to steal items of non-trivial value without confronting the victim (e.g. shoplifting) Y N

m. Problems controlling the urge to stay out at night, despite parental prohibition (before the age of 13) Y N

n. Problems controlling the urge to run away from home overnight (at least twice while living in the home of a parent or guardian or once without returning for a lengthy time period Y N

o. Problems controlling the urge to be truant from school (beginning before the age of 13) Y N

CN = 3

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time (list by letters):

_____

Have any of these problems gotten worse over the course of time (list by letters):

_____

D. Problems of Mood Control

a. Feeling depressed or irritable most of the day, nearly every day Y N

b. Decreased sense of pleasure during activities Y N

c. Decrease or increase in appetite or weight Y N

d. Difficulty falling asleep or sleeping excessively, nearly Y N

every day

e.	Feelings of restlessness	Y	N
f.	Feeling "slowed down"	Y	N
g.	Feeling fatigued; lack of energy	Y	N
h.	Feeling worthless or guilty	Y	N
i.	Decrease in ability to concentrate	Y	N
j.	Suicidal ideas or a suicide attempt	Y	N
k.	Low self-esteem	Y	N
l.	Feelings of hopelessness	Y	N

CN = 5 (2wks); a + 2 (2 yrs.)

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time (list by letter):

_____

Have any of these problems gotten worse over the course of time (list by letter):

_____

E. Problems of Anxiety:

a.	excessive anxiety and worry	Y	N
b.	avoidance of being alone	Y	N
c.	anxiety about sleeping alone	Y	N
d.	worry and excessive distress in anticipation of separation from parent/guardian	Y	N

e. excessive distress when separated from parents or guardian Y N

f. unrealistic worry about future events Y N

g. excessive need for reassurance Y N

h. marked inability to relax Y N

i. marked self-consciousness Y N

j. repeated nightmares Y N

k. repetitive non-functional rituals to reduce anxiety (e.g. hand washing; counting; checking) Y N

l. a specific fear or phobia (e.g. public places; animals elevators). Please list: _____ Y N

m. panic attacks Y N

n. discomfort with textures of specific foods or clothing Please list: _____ Y N

CN = 1

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time (list letters):

_____

Have any of these problems gotten worse over the course of time (list letters):

_____

F. Problems of Socialization & Communication:

a. Problems maintaining eye contact during social interactions Y N

b. Problems developing peer relationships as would be expected for the patient's age Y N

c.	Lack of behaviors that show a desire to share enjoyment, interests or achievements with others	Y	N
d.	Lack of social or emotional reciprocity	Y	N
e.	Delay in (or total lack of) the development of speech	Y	N
f..	Problems starting and maintaining a conversation with others (even though the patient is able to speak)	Y	N
g.	Conversation consists of repetition of the same topics	Y	N
h.	Problems in engaging in make-believe play or imitative social play that is appropriate for the patient's age	Y	N
i.	Preoccupation with one (or a relatively few) area of interest. The preoccupation is unusual in either intensity or focus	Y	N
j.	Rigid adherence to non-functional routines or routines. Patient will become agitated with even minor changes in routine	Y	N
k.	Repetitive, non-functional motor mannerisms (e.g. hand or finger flapping; twisting; or more complex total body posturing)	Y	N
l.	Preoccupation with the parts of objects	Y	N

CN(A) = 6; CN(ASP) = 2 (a-d) + 1 (i-l)

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time? (list letters)

_____

Have any of these problems gotten worse of the course of time? (list letters)

_____

G. Problems in Learning Academic Skills:

a.	Problem recognizing words when reading	Y	N
b.	Problem comprehending when reading	Y	N
c.	Problem maintaining visual focus when reading (skips from one line to another; words blur or move)	Y	N
d.	Problem learning basic mathematics facts (adding; subtracting; multiplication tables)	Y	N
e.	Problem recognizing how to solve word problems in mathematics	Y	N
f.	Problem learning how to form letters when writing	Y	N
g.	Problem learning how to spell words	Y	N
h.	Problem with spacing of words when writing	Y	N
i.	Problem expressing ideas in writing	Y	N

CN = 1

At what age did these problems begin? _____

Have any of these problems gotten better over the course of time? (list letters)

_____

Have any of these problems gotten worse over the course of time? (list letters)

_____

H. Problems of Language & Motor Coordination:

Were there any concerns about the patient's:

a.	Rate of learning to sit, crawl, walk, or run	Y	N
b.	Rate of learning to use toilet for urinating or bowel movements	Y	N

c. Rate of learning to speak Y N

d. Rate of learning how to tie shoelaces, button shirts dress self, hold eating utensils, assemble puzzles or build with blocks Y N

Does the patient show signs of motor or verbal tics? Y N

If yes, describe: _____

_____

_____

Does the patient urinate/defecate in their pants during the day or in their bed at night? Y N

If yes, how often? _____

CN = 1

At what age did these problems occur? _____

Have any of these problems improved over the course of time? Describe:

_____

Have any of these problems gotten worse over the course of time? Describe:

_____

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II. TREATMENT HISTORY:

Please indicate the types of treatment that you have tried in order to overcome the problems listed above:

a. Consulted with a physician Y N

Name: _____ Year: _____

Type of treatment? _____

_____

Name: _____ Year: _____

Type of treatment? _____

_____

Name: _____ Year: _____

Type of treatment? _____

_____

b. Consulted with a psychologist, social worker, psychiatric nurse or counselor Y N

Name: _____ Year: ____

Type of Treatment: _____

_____

Name: _____ Year: ____

Type of Treatment: _____

_____

Name: _____ Year: ____

Type of Treatment: _____

_____

c. Consulted with a speech therapist, occupational therapist, or physical therapist Y N

Name: _____ Year: ____

Type of Treatment: _____

_____

Name: _____ Year: ____

Type of Treatment: _____

_____

Name: _____ Year: ____

Type of Treatment: _____

_____

d. School Intervention Y N

1. Meeting with teacher and instructional support team Y N

2. Collaboration with the teacher(s) and school psychologist to develop a behavioral intervention plan Y N

3. Evaluation for learning disabilities by the school psychologist Y N

4. The development of an Individual Education Plan (IEP) Y N

5. The development of a 504 Plan Y N

Other Types of Treatment (e.g. Career Counseling; Coaching): Y N

Please describe: _____

_____

III. MEDICAL HISTORY:

The following sections are intended to provide your doctor or therapist with information about the potential causes of your problems:

A.. PRENATAL HISTORY: The following questions relate to the health of the patient's mother during pregnancy. Please circle your answers

1. Did the mother experience:

a.	a high level of stress during pregnancy	Y	N
b.	high blood pressure during pregnancy	Y	N
c.	anemia during pregnancy	Y	N
d.	excessive bleeding during pregnancy	Y	N
e.	urinary tract infections during pregnancy	Y	N
f.	toxemia	Y	N
g.	eclampsia	Y	N
h.	accidental injury that caused bleeding or loss of consciousness	Y	N
i.	carbon monoxide or lead poisoning	Y	N
j.	seizures	Y	N
k.	diabetes	Y	N
l.	any other medical problems	Y	N

list: _____

_____

2. Did the mother:

a. take any type of prescription medication for a psychiatric condition during pregnancy — Y N

Please List: _____

_____

b. take any type of prescription medication for any other disease or illness during pregnancy — Y N

Please List: _____

_____

c. smoke cigarettes during pregnancy — Y N

how often: _____

d. drink alcoholic beverages during pregnancy — Y N

how often: _____

e. drink coffee, tea, or other caffeinated beverages — Y N

how often: _____

f. smoke marijuana during pregnancy — Y N

how often: _____

g. use any other illegal drugs during pregnancy — Y N

what drugs: _____

how often: _____

B. BIRTH HISTORY

1. How old was the mother at the time of birth? _____

2. Was the pregnancy considered "full term" — Y N
If no: duration of the pregnancy: _____

3. Were there birth complications due to Rh factor incompatibility Y N

4. How long was labor (initial labor pains to childbirth): _____

5. How was the patient delivered? Vaginal Planned C-Section Emergency C-Section

6. Were instruments used? Forceps Suction

7. Did the patient present in the breech position? Y N

8. Was there fetal distress (variable heart rate with contraction)? Y N

9. Was the umbilical cord wrapped around the patient's neck? Y N

10. Did the patient ingest meconium? Y N

11. What was the patient's birth weight: _____ lbs. _____ oz.

12. Were there any problems with the patient's color at birth? Y N

Blue ? (cyanotic) Yellow? (jaundice)

13. Did the patient have any difficulty beginning to breathe? Y N

14. Was there any evidence of heart problems (irregular heart beat)? Y N

15. Did the patient have seizures? Y N

16. Did the patient develop any type of infection in the hospital? Y N

If yes, describe: _____

17. Did the patient require treatment in the NICU for any reason Y N

If yes, what type of treatment: _____

_____

18. How long did the patient remain in the hospital before release _____

C. MEDICAL HISTORY: INFANCY

1. Was the patient breast-fed? Y N

If yes, were there difficulties tolerating breast milk? Y N
Describe: _____

How long was the child breast-fed? _____

2. Was the patient fed a formula after birth? Y N

What type: Milk-based Soy-based Rice-based

If yes, were there difficulties tolerating formula? Y N
Describe: _____

3. Did the patient contract any type of disease or develop any medical condition during the first three months after birth? Y N

Describe: _____
_____

D. MEDICAL HISTORY: CHILDHOOD, ADOLESCENCE, ADULTHOOD

1. Did the patient experience more than two ear infections per year during the first five years of life? Y N

If yes, how many? _____

Were tubes inserted? Y N

Were tonsils surgically removed? Y N

Were adenoids surgically removed? Y N

2. Did the patient experience any significant side effects following any immunization vaccinations? Y N

If yes, describe _____

3. Did the patient ever ingest a toxic substance? (e.g. lead) Y N

If yes, what substance _____

4. Did the patient ever become ill from exposure to toxic vapors (e.g. carbon monoxide) Y N

If yes, what toxin _____

5. Did the patient contract a strep infection more than twice per year during the first five years of life? Y N

If yes, how many? _____

6. Is the patient allergic to any airborne allergen? Y N

If yes, describe _____

7. Is the patient allergic to any food? Y N

If yes, describe _____

8. Has the patient ever had a fever high enough to cause loss of consciousness or seizure? Y N

9. Has the patient ever had an injury to the head sufficient to cause nausea, vomiting, or loss of consiousness Y N

10. Has the patient ever experienced a seizure for reasons other than a fever? Y N

11. When was the patient's last hearing examination: _____

Who conducted the examination? _____

Was there any evidence of hearing loss? Y N

If yes, describe: _____

Has the patient ever been tested by an audiologist in order to evaluate auditory processing? Y N

Was a central auditory processing disorder identified? Y N

12. When was the patient's last vision examination: _____

Who conducted the examination ?_____ Y N

Was there any evidence of visual impairment? Y N

If yes, describe: _____

Were corrective lenses prescribed? Y N

Has the patient ever been tested by an optometrist or ophthalmologist in order to evaluate impairment of visual tracking or convergence? Y N

Were problems in tracking or convergence identified Y N
If yes, how were they treated? _____

13. Aside from "colds" and common infections, has the patient required medical treatment for any other disease or medical condition? If yes, describe: _____ Y N
_____
_____

MEDICAL EVALUATIONS

Has the patient's physician ever ordered laboratory tests for:

Anemia	Y	N	Thyroid Disorders	Y	N
Zinc Deficiency	Y	N	Magnesium Deficiency	Y	N
Iron Deficiency	Y	N	Vitamin B Deficiency	Y	N
Hypoglycemia	Y	N	Vitamin D Deficiency	Y	N
Diabetes	Y	N	Lyme Disease	Y	N
Celiac Disease	Y	N	Lead, Mercury, Metals	Y	N
Food Allergies	Y	N	Amino Acid Deficiency	Y	N
Estrogen	Y	N	Progesterone	Y	N
Growth Hormones	Y	N	Illegal Drugs	Y	N

Other Tests? (Please list):

_____

Any significant results? _____
_____

DIETARY, SLEEP & EXERCISE HABITS

Diet:

1. What does the patient eat for breakfast (i.e. between 6 and 10:30 A.M.)?

Meal Type 1: _____ How many days/week? ___

Meal Type 2: _____ How many days/week? ___

Meal Type 3: _____ How many days/week? ___

2. What does the patient eat for lunch (i.e. between 11 A.M. and 2 P.M.)?

Meal Type 1: _____ How many days/week? ___

Meal Type 2: _____ How many days/week? ___

Meal Type 3: _____ How many days/week? ___

3. What does the patient eat in the evening (i.e. after 5 PM)?

Meal Type 1: _____ How many days/week? ___

Meal Type 2: _____ How many days/week? ___

Meal Type 3: _____ How many days/week? ___

Snacks? _____ How many days/week? ___

Sleep:

1. What time does the patient go to bed? _____

2. How long does it usually take for the patient to fall asleep? _____

3. Does the patient wake during the night? _____ If yes, how often? _____

4. Does the patient move excessively while sleeping? Y N

5. Does the patient walk during sleep? Y N

6. Does the patient snore during sleep? Y N

7. Has the patient ever been evaluated for sleep apnea? Y N

If yes, describe results: _____

_____

8. What time does the patient wake in the morning? _____

9. At waking, does the patient feel fatigued? Y N

Exercise:

1. How many days per week does the patient engage in at least 30 minutes of exercise? _____

2. What types of exercise does the patient do? Describe: _____

_____

_____

_____

3. Does the patient experience shortness of breath or chest pains when exercising? Y N
If yes, has the patient been evaluated by a physician? Y N

Describe the results of such an evaluation: _____

_____

_____

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PSYCHOACTIVE SUBSTANCE USE

Please indicate any substance that the patient uses:

Substance	Current Use/per day	Current Use/per week
Caffeine	_____	_____
Nicotine	_____	_____

Substance	Current Use/per day	Current Use/per week
Beer	_____	_____
Wine	_____	_____
Liquor	_____	_____
Marijuana	_____	_____
Cocaine	_____	_____
Other Drugs:		
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient ever used any substance more frequently than currently used?

Please describe: _____

_____

_____

Has the patient ever participated in treatment for drug/substance abuse problems?

Please describe: _____

_____

_____

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EDUCATIONAL/WORK HISTORY

1. What is the highest grade completed by the patient? _____

Name of High School: _____

Name of College/University: _____

Name of Graduate School: _____

Was the patient ever retained in a grade? Y N

Did the patient ever have to attend summer school due to academic failure? Y N

If yes: List subject(s): _____

Did the patient ever need tutoring or remedial instruction? Y N

If yes: List subject(s): _____

3. What is the patient's current occupation? _____

4. How many jobs has the patient held in the past ten years? _____

5. Has the patient ever been terminated from a job due to problems related to attention, accuracy, organization, or timely completion of tasks? Y N

6. Has the patient ever quit a job due to problems related to attention accuracy, organization or timely completion of tasks? Y N

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FAMILY HISTORY

Has any blood relative of the patient (e.g. grandparents, parents, brothers, sisters, aunts, uncles, cousins) ever shown symptoms of any of the following

a. alcoholism (e.g. intoxication more than six times per year; problems controlling drinking habits; blackouts) Y N

b. drug abuse (e.g. "getting high" more than six times per year; problems controlling use of drugs like pot) Y N

c. obesity (e.g. weight control problems) Y N

d. depression (e.g. a pervasive sense of sadness that lasts for weeks, months, or years Y N

e. ADHD (e.g. difficulty concentrating while listening or reading, disorganization, procrastination, forgetfulness or impulsivity and restlessness) Y N

f. compulsive gambling (e.g. inability to control the urge to wager more than the person could afford; needing to borrow money to repay gamblings debts; inability to pay household bills because of gambling losses) Y N

g. frequent loss of temper (e.g. yelling, cursing, swearing, throwing things or hitting others when frustrated on a daily or weekly basis) Y N

h. learning disorders (e.g. difficulty learning to read, write, or solve math problems; retention in a grade; special education class) Y N

i. anxiety (e.g. experiencing a sense of nervousness and tension that lasts for weeks, months, or years Y N

j. panic disorder (e.g. experiencing a sudden, intense state of anxiety that is so intense that the patient is unable to function) Y N

k. sexual addiction (e.g. engaging in sexual behavior that is dangerous from a health perspective or threatens the stability of a relationship) Y N

l. criminal actions (e.g. arrest and conviction for activities other than driving) Y N

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MARITAL HISTORY

1. Has the patient ever been married? Y N

If yes, how many times? _____

Is the patient currently married? Y N

2. Is there a history of divorce in the patient's family? Y N

If yes, did the patient experience the divorce of parents? Y N

At what age _____

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Thank you for completing this questionnaire. If there are any questions or problems that you would like to discuss with your doctor or therapist in more detail, please list here:

19 Item COVD-QOL Checklist Questionnaire

Check the column which best represents the occurrence of each symptom

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
1. Headaches with near work					
2. Words run together reading					
2. Burn, itch, watery eyes					
4. Skips/repeats lines reading					
5. Head tilt/close one eye when reading					
6. Difficulty copying from chalkboard					
7. Avoids near work/reading					
8. Omits small words when reading					
9. Writes up/down hill					
10.Misaligns digits/columns of numbers					
11. Reading comprehension down					
12. Holds reading too close					
13.Trouble keeping attention on reading					
14. Difficulty completing assignments on time					
15. Always says "I can't" before trying					
16. Clumsy, knocks things over					
17. Does not use his/her time well					
18. Loses belongings/things					
19. Forgetful/poor memory					

OTHER COMMENTS:

FPI Attention Disorders Clinic

94 Marshall Dr., Endicott, NY 13760 Phone: 607-785-0400 Fax: 607-785-0077

Consent for Release of Information

I/we the undersigned, give consent for _____

to provide the following information to DR. MONASTRA

of the FPI Attention Disorders Clinic:

____ Medical records (including physician notes, laboratory and imaging results)

____ Psychological Evaluation/Test Report

____ Treatment Summary

____ Psychiatric Examination/Discharge Summary

____ School Transcripts/Academic Records

____ Written Teacher Reports

____ CSE Summary/ IEP/ 504 Accommodation Plans

____ Professional Conversations regarding diagnostic and/or treatment issues

____ Other: _____

I understand that disclosure of this information to anyone other than those listed above is prohibits. I also understand that I have the right to cancel my permission at any time before information is released. My consent to release information will expire 90 days from this date if not acted upon prior to that time.

Patient Name: _____ Date of Birth: _____

Parent (Guardian) Signature (if patient is a minor) _____

Adult Patient's Signature: _____ Date: _____

FPI Attention Disorders Clinic, 94 Marshall Dr., Endicott, NY 13760
Phone: 607-785-0400 Fax: 607-785-0077

Consent for Release of Information

I/we the undersigned, give consent for Dr. Monastra and the FPI Attention Disorders Clinic to provide the following information to:

___ Physician's Name: _____
___ School District: _____
___ CSE Chairperson: _____
___ Office for Students with Disabilities _____
___ Other: _____

_____ Psychological Evaluation/Test Report: Includes written presentation of

- Medical, developmental and social history
- Clinical observations during evaluation
- Test results
- Interpretation of test results, diagnosis and recommendations.

_____ Treatment Summary: Includes written description of

- Reasons treatment was requested
- Diagnosis
- Treatment plan
- Outcome of therapy and clinical status at time treatment was concluded

_____ Discussion of diagnostic or treatment issues: Includes professional conversations Regarding psychological evaluation or treatment as described above. However, no Written report is authorized.

_____ Billing Claims Submission: Includes verbal and written communication about diagnostic And treatment issues necessary for processing of insurance claims

_____ Other: _____

I understand that such disclosure is bound by regulations governing the confidentiality of medical/psychological records and the release of this information to a party other than the one(s) designated above is prohibited without additional written authorization on my part. I also understand that I can cancel my permission to release information at any time before it is released. My consent to release this information will expire 90 days from this date if not acted upon prior to that time.

Patient: _____ Date of Birth _____

Parent (Guardian) Signature (for minors) _____ Date _____
Adult Patients Signature: _____ Date _____