Heilsugæsla höfuðborgarsvæðisins
Geðheilsuteymi HH-ADHD fullorðinna
Lágmúli 6-8, 108 Reykjavík
+(354) 513-6730

CLIENT APPLICATION FORM

REGARDING REFERRAL TO GEÐHEILSUTEYMI HH - ADHD FULLORÐINNA

If client has a prior diagnosis of ADHD a copy of the diagnostic report must be sent along with the referral.

Client approval form can be found on the last page.

Please answer the following questions as best as you can and make sure not to leave any questions unanswered. Remember that the information given will go into your medical record.

Name:
Icelandic social security number/ identification number:
Age:
Telephone number:
Email:

Work status

□ Working

□ Student

□ Receiving disability pension. If yes, why: _____

□ Unemployed

□ Other, what? _____

Marital status?

□ In a relationship, married or cohabitating

□ Single

Do you have children?

□ Yes, how many? _____

□ No

What is your living arrangement?

□ Own place

□ Rent

□ Social services apartment

□ Institution

□ Live with relative/friends

□ Other

Do you receive any kind of social services assistance?

□ Yes. What kind? _____

□ No

Have you ever received a diagnosis of attention deficit/hyperactivity (ADHD) before? *If an older diagnosis exists a diagnostic report needs to accompany the referral to the ADHD psychiatric healthcare team.*

□ Yes, where from and which year? _____

□ No

Does anyone in your family have an ADHD diagnosis?

□ Yes. Who? _____

□ No

□ Don´t know

Does anyone in your family have a diagnosis of autism or Tourette's?

□ Yes, who? _____

□ No

□ Don´t know

Do you know if there were any problems during pregnancy or your birth?

□ Yes. Please explain _____

□ No

□ Don´t know

Did you have any childhood diseases?

□ Yes. Please explain_____

□ No

Did you start to walk and talk at a normal age

□ Yes

□ No. Please explain _____

□ Don´t know

Did your parents or teachers worry about your behaviour or development during preschool?

□ Yes. What did they worry about and at what age were you?

_____

□ No

Did your parents or teachers worry about your behaviour during elementary school?

□ Yes. What did they worry about? _____

□ No

Did you have problems sleeping as a child?

□ Yes. Please explain _____

□ No

Did you have trouble communicating with your peers as a child?

□ Yes. Please explain _____

□ No

What educational level have you finished?

□ Did not finish elementary school

□ Elementary school

□ Secondary school /Trade school

□ University

□ Other, what? _____

How were your grades in elementary school compared to your classmates?

□ Below average

□ Average

□ Above average

If secondary school, how were your grades then?

□ Below average

□ Average

□ Above average

How often have you started but not completed school? _____

Did you ever need special tutoring or special aid in your studies?

□ Yes. What kind? _____

□ No

Have you ever been diagnosed with dyslexia or any other learning disability?

□ Yes. What kind? _____

□ No

Please write your job history (what jobs and at what time)?

_____

_____

_____

_____

Have you ever experienced head trauma or lost consciousness due to a blow to the head?

□ Yes. How often? _____

□ No

Are there any known mental illnesses in your family?

□ Yes. Please explain: _____

□ No

□ Don´t know

Do you have any mental illnesses such as anxiety, depression or other?

□ Yes. Please explain _____

□ No

Have you ever sought help because of mental and/or behavioural problems?

□ Yes. Before the age of 18, please explain: _____

□ Yes. As an adult. Please explain: _____

□ No

Are you taking any medication because of mental problems?

□ Yes. Which medication? _____

□ No

Are you receiving other kind of treatment than medicinal because of mental problems?

□ Yes. What treatment? _____

□ No

Where have you sought help because of mental and/or behavioural problems?

□ I have not sought help

□ Landspítali, mental health unit

□ SÁÁ

□ BUGL (Landspítali, children and teen mental health unit)

□ Mental health unit of FSA in Akureyri

□ Mental health unit at Reykjalundur

□ Mental health teams of health care (Heilsugæslu/Heilbrigðisstofnana)

□ Healthcare

□ Private practice Psychiatrist

□ Private practice Psychologist

□ Other private practice therapist

□ Other. Please explain: _____

Have you ever been arrested?

□ Yes. How often? _____

□ No

Have you ever been convicted of a crime?

□ Yes. What kind? _____

□ No

Have you ever served time in prison?

□ Yes. What for and how long? _____

□ No

Has consumption of alcohol or other intoxicants been a problem?

□ Yes. Please explain: _____

□ No

Have you ever had treatment for alcohol or narcotics addiction?

□ Yes. Please explain: _____

□ No

How often do you consume alcohol?

□ Never

□ Never in the last year

□ Never in the last six months

□ Less than once a month

□ Once a month

□ A few times every month

□ Weekly

□ A few times a week

□ Daily

How often do you use narcotics?

□ Never

□ Never in the last year

□ Never in the last six months

□ Less than once a month

□ Once a month

□ A few times every month

□ Weekly

□ A few times a week

□ Daily

Do you smoke?

□Yes. How many cigarettes a day approximately? _____

□ Yes. However, I am trying to quit

□ No. Used to before

□ No. Never smoked

CLIENT AGREEMENT FORM

I hereby give consent for this application/referral to Geðheilsuteymi HH – ADHD fullorðinna along with giving permission to the ADHD team to contact named family members or friends to acquire further information about my symptoms and behaviour.

In agreement, write your name and Icelandic social security number/ identification number:

Name: _____

Icelandic social security number/ identification number:

_____

Name of one or two family members or friends to be contacted concerning symptoms and behaviour during childhood and adulthood (same as filled out rating scales):

Name[1]:_____

Relation: _____

Tel: _____

Name[2]:_____

Relation: _____

Tel: _____

Please mark if no family member or friend exists:

□ No family member or friend