

Registration Details

Name of Patient: _____

Date of Birth: _____

Address: _____

Postcode: _____

Email Address: _____

Telephone Number: _____

If child:

Name of Parent/Guardian: _____

Relationship to Patient: _____

Email Address: _____

Phone Number: _____

Short line or two about what has led you to thinking you/your child may ADHD:

I am aware that I am completing these questionnaires to provide information to an ADHD specialist to advise whether an ADHD assessment would be beneficial to me.

I have read and understood the Privacy Policy on the ADHD Clinic Website: www.theadhdclinic.co.uk/privacy-policy