central+ priority PEDIATRICS

ADHD Follow-up

Child's Name_____ Date Completed_____ Completed by: Mother Father Other:_____
Medication _____ Dose _____
How often does your child take medication? (circle one) : Every day School days School days and occasional weekends
What exact time(s) does your child take medication? Morning:_____ Lunch:_____ Afternoon/Evening:_____
What exact time do you feel the medication stops working? _____
What Grade is your child in?:_____ What school does your child attend?_____
Primary Teacher/Counselor Name:_____
How is your child doing academically?

Do you or the teachers have any concerns about your child's behavior at school?

How well does the medication control target symptoms?	Well	Somewhat	Poorly
Hyperactivity	☐	☐	☐
Attention Span	☐	☐	☐
Being distracted	☐	☐	☐
Finishing Tasks	☐	☐	☐
Being Impulsive	☐	☐	☐
Getting frustrated easily	☐	☐	☐
Accepting Limits	☐	☐	☐
Getting along with friends	☐	☐	☐

Is your child experiencing any of the following side effects from medication?	Yes	No
Loss of appetite/weight	☐	☐
Trouble falling asleep	☐	☐
Trouble staying asleep	☐	☐
Irritability or anxiety when the medication wears off	☐	☐
Sadness or crying unexpectedly	☐	☐
Tics or nervous habits	☐	☐
Headaches	☐	☐
Stomachaches	☐	☐
Trouble interacting socially with others	☐	☐
Worrying unnecessarily	☐	☐
Feeling tired	☐	☐
Changes in stools	☐	☐

	Yes	No
Do you have concerns about your child's mood?	☐	☐
Do you have any concerns about your child's behavior at home?	☐	☐
Are there any changes to the home or family enviroment?	☐	☐
Have any new medical problems developed since the last visit?	☐	☐

If you answered yes to any of these questions please explain: