
**Partners in Pediatrics, LLC**

*Partners with Parents for the Health of their Children*

# ADHD Follow-Up Questionnaire

**(Please fill out based on your child's progress since the last visit reviewed with your physician)**

**Today's Date** _____

**Patient Name** _____ **Date of Birth** _____

**Form Filled Out By** _____

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SYM

## Medication(s) Currently Taking

SYM

**#1** _____ @ _____ **#2** _____ @ _____

Name of Medication & Dosage — Time Taken — Name of Medication & Dosage — Time Taken

**#3** _____ @ _____ **#4** _____ @ _____

Name of Medication & Dosage — Time Taken — Name of Medication & Dosage — Time Taken

Is your child's medicine helping? ____ yes ____ no

Do you want to continue the current medicine(s)? ____ yes ____ no

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QUA

## CHECK any CHANGES you have seen in your child since the last visit:

QUA

| | Same | Improved | Worse |
|---|---|---|---|
| Attention at Home | _____ | _____ | _____ |
| Attention at School | _____ | _____ | _____ |
| Hyperactivity | _____ | _____ | _____ |
| Conduct | _____ | _____ | _____ |
| Organization | _____ | _____ | _____ |

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SEV

## CIRCLE any PROBLEMS you are noting in your child since the last visit:

SEV

Disorganized ♦ Problems with Homework ♦ Teacher Concerns ♦ Anxiety

Problems with Friends ♦ Sadness ♦ Problems with Family ♦ Tics or Unusual Movements

Test Taking Difficulty ♦ School Suspensions

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TIM **What time does your medicine stop working?** _____ ___TIM

**Does your child take meds on weekends? holiday?**_____

**Are you concerned with your child's appetite and when?**_____

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CON

## CIRCLE any SIDE EFFECTS noted:

CON

Irritability ♦ Trouble Falling Asleep ♦ Headaches ♦ Stomach Aches ♦ Loss of Appetite ♦ Weight Loss

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MOD **Is your child getting any special help/services at school? ____ yes ____ no** MOD

If yes, please describe _____

School Name _____Grade_____