Kids Health Alliance, LLC

Patient Name: _____ Date: _____

PLEASE FILL IN BUBBLES COMPLETELY:

For past 4 weeks how is your child doing in following areas ?

Attention at School:	O Excellent	O Good	O Fair	O Poor
Attention at Home:	O Excellent	O Good	O Fair	O Poor
Organization:	O Excellent	O Good	O Fair	O Poor
Homework Assignment:	O Excellent	O Good	O Fair	O Poor
School Behavior:	O Excellent	O Good	O Fair	O Poor
After School Activities:	O Excellent	O Good	O Fair	O Poor
Social Interactions:	O Excellent	O Good	O Fair	O Poor
Family Participation:	O Excellent	O Good	O Fair	O Poor
Hyperactivity:	O Never	O Occasional	O Often	O Very Often
Impulsivity:	O Never	O Occasional	O Often	O Very Often
Forgetfulness:	O Never	O Occasional	O Often	O Very Often
Distractibility:	O Never	O Occasional	O Often	O Very Often
Disruptive Behaviors:	O Never	O Occasional	O Often	O Very Often
Accidents/Injuries:	O Never	O Occasional	O Often	O Very Often
Medication effect lasts:	O 12hrs	O 10hrs O 8hrs	O 6 hrs	O <6 hrs
Taking Medication Daily:	O Yes	O No		
Needs change in medication?	O Yes	O No		

ADHD MEDICATION SIDE EFFECTS:

Appetite:	O Good	O Fair	O Poor O Improved	
Sleep:	O Good	O Fair	O Poor O Improved	
Stomach Aches:	O None	O Occasional	O Frequent	O Improved
Headaches:	O None	O Occasional	O Frequent	O Improved
Tremors:	O None	O Occasional	O Frequent	O Improved
Rebound Symptoms:	O None	O Occasional	O Frequent	O Improved
Skin picking, nail biting:	O None	O Occasional	O Frequent	O Improved
Lip or Cheek chewing:	O None	O Occasional	O Frequent	O Improved
Hallucinations:	O None	O Occasional	O Frequent	O Improved
Abnormal Face Movement:	O None	O Tongue Thrusts	O Jaw Clenching	O Chewing
Motor Tics:	O None	O Twitching	O Eye Blinking	O Face Movements
Mood:	O Normal	O Depressed	O Anxious	O Irritable O Withdrawn

Please feel free to write down if you have any other questions or concerns in the space below including the back of this page:

_____

Name and Signature of person filling out this form