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Pediatric Physicians, PC

ADD/ADHD Feedback

Founded by Dr. Patty, 1992

Name: _____ DOB: _____

Main concerns:

ADD

Date: _____

Time: _____

Grade: _____ School: _____ Teacher: _____

Medications:

Drug Name	Dose/time	Dose/time	Dose/time

Side Effect Profile:

- Yes / No Any trouble with eating their meals?
Yes / No Any trouble sleeping at night?
Yes / No Any rebound moodiness or irritability?
Yes / No Any unusual behaviors/tics?
If yes describe: _____

Does your child take medication on weekends and vacations? Yes / Sometimes / No

Evaluation of Progress: Rate 0-4 (never=0 always=4) (Please rate patient's symptoms while on medication)

- | | |
|------------------------------------------------------------------------------|-----------------------------------------------------------------|
| ___ Rushes through homework and chores | ___ Interrupts others when speaking |
| ___ Is easily distracted by other activities | ___ Is easily angered or annoyed |
| ___ Does not hear all that is said | ___ Reacts immediately without thinking |
| ___ Is unsuccessful in activities that require listening | ___ Ignores the consequences of their behavior |
| ___ Requires eye contact to get directions | ___ Hops, skips, constantly moving |
| ___ Has difficulty concentrating (following a conversation, staying on task) | ___ Handles objects (twirls pencil, clicks pens, taps table...) |
| ___ Fails to complete or turn in homework | ___ Becomes overexcited easily |
| ___ Completes assignments with little regard to neatness | ___ Engages in nervous habits |

Overall Parent's Assessment: check one box for each

	Excellent	Good	Fair	Poor
Making and keeping friends				
Getting along with the family				
Success in school				

This information was provided by: _____ Relationship to patient: _____