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Pediatric Physicians, PC

Founded by Dr. Patty, 1992

Medication feedback

Name: _____ DOB:_____

Main concerns:

Date:_____

Grade:_____ School:_____

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
__ Is easily distracted by other activities
__ Does not hear all that is said
__ Has difficulty staying on task
__ Fails to complete or turn in homework
__ Completes assignments with little regard to neatness
__ Interrupts others when speaking
__ Reacts immediately without thinking
__ Ignores the consequences of their behavior

__ Hops, skips, constantly moving
__ Seems uninterested or bored
__ Is easily angered or annoyed
__ Tires easily or has low energy
__ Often complains of aches or pains
__ Is unhappy
__ Worries
__ Gets thoughts "stuck" in head
__ Feels bad

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: _____