valley pediatrics of greenwich

ADHD MEDICATION RECHECK VISIT (PARENT QUESTIONNAIRE)

Patient name:

Date form completed:

Form completed by:

Medications (list all including ADHD medications, including dose and time(s) of the day):

1.

2.

Please list any chief concerns you or the teacher have about your child's ADHD:

Has your child met the ADHD Management Plan goals developed at the previous visit (if applicable)?

___Yes ___No

How is your child's home performance (please comment on child's ability to do homework and chores and on your child's interpersonal behaviors with family and friends)?

Please mark any side effects your child has from medications:

__systemic symptoms __mood disturbance __tics __ chronic/recurring headaches __decreased appetite __nausea __decreased functioning ability __socially inappropriate behavior __interpersonal relationship problems with peer group

Does your child have an IEP or 504 Plan in place at school? __Yes __No

If yes, please list modifications in place:

Does your child see any other clinicians (psychologist, counselor, therapist, etc.)? __Yes __No

If yes, please list that person's name: