

ADHD – Diagnose, Treat, and Monitor

Checklist of Medication Follow-Up Questions

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| <input type="checkbox"/> In-person, completed by parent: _____ | | Date: ___ / ___ / ___ |
| <input type="checkbox"/> By phone, completed by staff: _____ | | |
| 1. Has your child started taking the medication prescribed? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If not, why? | | |
| If yes, when did medication start? | | |
| 2. Please verify the ADHD medicine your child is currently taking. What is/are the medication name(s) and dose? _____ | | Time: _____ <input type="checkbox"/> Home <input type="checkbox"/> School How: _____ |
| At what time, where, and how is the medication administered? | | |
| How many tablets (or milliliters if liquid) of your child's ADHD medication are left? | | |
| Do you need a refill of your child's ADHD medication? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you noticed any improvement toward your child's target goal(s)? If yes, what has improved? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you noticed any change in your child's ADHD symptoms? If yes, what has improved or worsened? _____ What time of the day do you notice a change in symptoms? _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What changes have been noticed in your child's behavior at home and at school? | | |
| 5. How has your child's performance at school changed (eg, homework completion, tests, progress reports)? Explain changes: _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does your child have any side effects from the medication? Examples include headache, stomachache, change in appetite, trouble sleeping, irritability, socially withdrawn, extreme sadness or unusual behavior, tremors/feeling shaky, repetitive movements, picking at skin/fingers/nails, sees or hears things that aren't there, or other issues. | | <input type="checkbox"/> Yes <input type="checkbox"/> No Side effects: _____ |
| 7. What time of day does the medication stop working? | | |
| 8. What questions or concerns do you have? | | |