

Premier Pediatrics, LLC

Patient Name: _____

Date: _____

PLEASE FILL IN BUBBLES COMPLETELY:

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

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

ADHD MEDICATION SIDE EFFECTS:

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- Mood: Normal Depressed Anxious Irritable Withdrawn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