How Are We Doing Managing Your ADHD

Name: _____ **Date:** _____

Any Medication Changes Since Last Visit? ☐ **No** ☐ **Yes, Explain:**

Medication Name	Dosage	Frequency	Duration
	____ mg ____ # tabs Time taken: ____ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
	____ mg ____ # tabs Time taken: ____ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate

Our goal at Attention-MD NJ is to control the ADHD symptoms without changing YOU! ***How are we doing?***

☐ My medication is at goal. I'M FOCUSED!

☐ I don't like my medications because _____

☐ My medication helps but I think my dose is ☐ not quite high enough ☐ is too strong

☐ My medication doesn't seem to be improving my symptoms enough.

NICHQ Vanderbilt Assessment Follow-Up – PARENT INFORMANT

ADHD Symptoms Since Last Visit **Please rate the severity of these problems:** **0-Never, 1- Occasionally, 2-Often, 3-Very Often**	**Rate:**	Side Effects Since Last Visit **Please rate ongoing problems with:** **0-None, 1-Mild, 2-Moderate, 3-Severe**	**Rate:**
Does not pay attention to details or makes careless mistakes with, for example, homework		Headache	
Has difficulty keeping attention to what needs to be done		Stomachache	
Does not seem to listen when spoken to directly		Trouble Sleeping	
Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)		Irritability in the late morning, late afternoon, or evening— Explain Below	
Has difficulty organizing tasks and activities		Change of Appetite – Explain Below	
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort		Socially withdrawn—decreased interaction with others	
Loses things necessary for tasks or activities (toys, books, etc)		Repetitive movements, tics, jerking, twitching, eye blinking—Explain Below	
Is easily distracted by noises or other stimuli		Dull, tired, listless behavior	
Is forgetful in daily activities		Tremors/feeling shaky	
Fidgets with hands or feet or squirms in seat		Extreme sadness or unusual crying	
Leaves seat when remaining seated is expected		Sees or hears things that aren't there	
Runs about or climbs too much when remaining seated is expected		Picking at skin or fingers, nail biting, lip or cheek chewing—Explain Below	
Has difficulty playing or beginning quiet play activities		**Performance**	
Is "on the go" or often acts as if "driven by a motor"		**Please rate performance with:** **1-Excellent, 2-Above Average, 3-Average** **4-Somewhat of a Problem, 5-Problematic**	**Rate:**
Interrupts or intrudes in on others' conversations and/or activities			
Blurts out answers before questions have been completed		Overall school performance	
Has difficulty waiting his or her turn		Reading	
Talks too much		Writing	
Total Symptoms Score:		Mathematics	
Explain/Comments:		Relationship with parents	
		Relationship with siblings	
		Relationship with peers	
		Participation in organized activities (sports)	
		Average Score of Performance Indicators:	

Name: _____ Date: _____

Our goal is for you to feel less anxious and/or depressed without suppressing normal worry, sadness, or joy.

Medication Name	Dosage	Medication Name	Dosage
	____ mg ____# tabs Time taken: ____ am/pm Taken daily? ☐ Yes ☐ No		____ mg ____# tabs Time taken: ____ am/pm Taken daily? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

Rate how much your symptoms have improved:	0%	25%	50%	75%	>75%
Anxiety	☐	☐	☐	☐	☐
OCD Symptoms	☐	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	☐
ODD Symptoms	☐	☐	☐	☐	☐

Symptom Frequency:	
My symptoms occur:	☐ More often ☐ Less often ☐ As often as before
My symptoms last:	☐ All day ☐ Several hours a day ☐ An hour or less a day

In the past two weeks, how often have you been bothered by the following problems?
0 – Not at all 1 – Several days 2 – More than half the days 3 – Nearly every day

Feeling nervous, anxious, or on edge	☐	Rigid, "My way or the highway"	☐
Not being able to stop or control worrying	☐	Sorting, organizing, lining things up, symmetry	☐
Worrying too much about different things	☐	Checking doors, lights	☐
Trouble relaxing	☐	Need to finish	☐
Being so restless that it is hard to sit still	☐	Erasing or having trouble getting started	☐
Becoming easily annoyed or irritable	☐	Hand washing, aversion to contamination	☐
Feeling afraid as if something awful might happen	☐	Repeat words & phrases, re-traces letters & numbers	☐
TOTAL SCORE:	☐	Picking at skin, nails, lips, twirling/pull hair	☐
If you checked off any above problems, **how difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely		Need to know – ask over and over	☐
		Need to tell – has to have last word or tell detail	☐
		Rituals, doing things in certain order	☐
		Counting random things, "good" or "bad" numbers	☐

Little interest or pleasure in doing things	☐	Argues with adults	☐
Feeling down, depressed, or hopeless	☐	Loses temper	☐
Trouble falling or staying asleep, or sleeping too much	☐	Is touchy or easily annoyed by others	☐
Poor appetite or overeating	☐	Deliberately annoys people	☐
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	Actively defies adults or refuses to go along with requests	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	Blames other for his or her mistakes or misbehaviors	☐
		Is angry or resentful	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	Is spiteful or wants to get even	☐
		Additional Comments:	
Thoughts that you would be better off dead or of hurting yourself in some way	☐		
TOTAL SCORE:	☐		

Provider Comments:

☐ **Remission** ☐ **Improvement** ☐ **Persistent** ☐ **Worsening**