

ADHD PROGRESS REPORT

Cockerell & McIntosh Pediatrics, P.C.

Date: _____

Patient Name: _____ Date of Birth: _____

Current Medications & Doses:

Please check the box that corresponds to your child's current symptoms.

Core Symptoms	Not a Problem	Mild Problem	Moderate Problem	Severe Problem
Attention at school				
Attention at home				
Hyperactivity				
Impulsivity				
Forgetfulness				
Distractibility				
Organization				
Secondary Symptoms				
Homework				
School behavior				
After school activities				
Social interactions				
Family participation				
Disruptive behaviors				
Accidents/injuries				

Please check the appropriate box.

Adverse Events	Good	Fair	Poor	Improved
Appetite				
Sleep				
Adverse Events	None	Occasional	Frequent	Improved
Tics				
Stomach ache				
Headaches				
Tremors				

Circle One

Mood: Pleasant Depressed Anxious Oppositional Other
 Duration medication works: 12hrs 10hrs 8hrs 6hrs 4hrs Less

Does your child take medication on the weekends? Yes No

How many doses of medication did your child miss this month? _____

Other side effects: _____

Other Comments: _____

Parent/Guardian Signature: _____