

# ADHD PROGRESS REPORT

*Cockerell & McIntosh Pediatrics, P.C.*

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Grade in school: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Name of child's teacher if in elementary school: \_\_\_\_\_

Please list 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				

**Please Circle**

Child's mood:                      Pleasant              Depressed              Anxious              Oppositional              Other

Change in mood:                      Better              Worse              Same

Academic performance:              Above Average              Average              Below Average              Failing

Any extra help:                      IEP              504 plan              Tutoring              Special classes

How long medication works:              12hrs              10hrs              8hrs              6hrs              4hrs              Less

Is your child seeing a behavioral counselor, therapist, or psychologist?    Yes    No

Does your child take medication on the weekends?    Yes    No                      During the summer? Yes    No

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

Other side effects: \_\_\_\_\_

Other comments: \_\_\_\_\_