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 while on medication.

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: _____