3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

ADHD Medication Recheck Visit

Patient Name:____ Date of Birth:____/____/_______
Date of Form Completion:____/____/_______
Form completed by: ___________________________
Current school/grade: __________________________/ _________________
Teacher's name/ number: ______________________ / __________________
Couselor's name/ number:______________________ / __________________

Medications (list all ADHD medications, including dose and time(s) of day taken):
1.
2.
3.

Please list any concerns that you or the teacher have about your child's ADHD:

Has your child met the ADHD management goals developed at the previous visit (if applicable)? No__ Yes___

How is your child's school performance? Please comment on grades, performance on standardized tests, discipline issues, etc.

How is your child's home performance? Please comment on child's ability to do homework and chores and on your child's interpersonal behaviors with family and friends.

Please mark any side effects your child has from the medication:

___fatigue/sedation ___mood disturbance ___tics ___decreased appetite ___frequent headaches
___nausea___inappropriate behavior ___interpersonal relationship problems with peers/siblings
___stomachaces ___weight loss ___ insomnia ___tremors ___picking at skin/nails ___nail-biting

Does your child have an IEP or 504 Plan in place at school? No__ Yes___

If yes, please list modifications in place:

Does your child see any other clinicians (psychologist, counselor, therapist, etc.)? No__ Yes___

If yes, please list that person's name: