

# ADHD Appointment Check Up

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Tell us how things are going

Today's Date: \_\_\_\_\_

Patients Name: \_\_\_\_\_ Birthday \_\_\_\_\_

Current ADHD Medication Name: \_\_\_\_\_

Dosage of Medication: \_\_\_\_\_

Check any of the following symptoms your child is experiencing with new medication:

- |  |   |
|--|---|
| <input type="checkbox"/> Agitation                   | <input type="checkbox"/> Nausea                                       |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Picking at fingers, nail biting, lip chewing |
| <input type="checkbox"/> Change of appetite          | <input type="checkbox"/> Repetitive Movements tics, twitching         |
| <input type="checkbox"/> Dizzy                       | <input type="checkbox"/> Vomiting                                     |
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Heart Pounding                               |
| <input type="checkbox"/> Insomnia (trouble sleeping) | <input type="checkbox"/> Extreme sadness or unusual crying            |

**Improvement rating:** *What changes have you noticed since your child's last visit?*

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*Check the box that applies to how things are going at home and school.*

	None	Mild	Moderate	Significant
Home				
School				

Thanks! Bring this with you to the exam room and share it with your provider.

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