Patient Name:

Date of Birth:

Patient Questionnaire

Today's Date: _____

This form is to be filled out by the patient.	Yes	No
1) Are the medications you are taking for ADHD helping?		
2) Can you pay more attention in class?		
3) Is it easier to do your homework?		
4) Can you organize your day's activities better?		
5) Is there less stress in your school and home life?		
6) Do you notice when the medication is wearing off?		
7) Does the medication wear off too soon?		
8) Do you skip any meals?		
9) Are you having problems going to sleep at night?		
10) Are there any side effects to the medication that concern you?		

Comments:_____

_____

_____

Patient Name:

Date of Birth

ADHD Assessment Monitoring

Parent Questionnaire

Today's Date: _____

Who is filling out this form? **Name:_____** **Relationship to patient_____**	**Yes**	**No**
1) Are the medications for your child helping the ADHD?		
2) Can your child pay more attention in class?		
3) Is it easier to get your child to do homework?		
4) Is your child's behavior better?		
5) Is the medication lasting long enough?		
6) Have you noticed your child eating less lately?		
7) Is your child having problems going to sleep at night?		
8) Has your child developed any movement or vocal tics?		
9) Has your child complained about feeling bad on the medication?		
10) Are there any side effects of the medication that concern you?		

Comments:_____

_____

_____