



ADHD Follow Up Appointment

Office Use Only

VFC: [] MDD/DKC
[] Native
[] NO Insurance
[] Not Eligible

INSURANCE Notes

Office Use Only

WT: _____ lb
_____ kg
Height: _____
BMI: _____
B/P: _____
Pain Scale: _____

Child's name: _____

Child's birthday: _____

When was your child diagnosed with ADD/ADHD? _____
Is your child taking medication for ADD/ADHD? Yes/no. What medication/dose? _____
How long has your child been at the current dose? _____
Do you think the current dose is effective? Yes/no. explain _____
What other medications has your child tried? _____
Does the medication help with behavior at home? Yes/no. explain _____
Does the medication help with behavior at school? Yes/no. explain _____
Is there a time of day behavior is of more concern? Yes/no. explain _____
Does your child have an IEP in place? Yes/no. explain _____
Does your child have any learning disabilities? Yes/no. explain _____
Parent/guardian comments _____

Review of systems/medication side effects:

Headache yes/no. If yes, how long? _____
Chest pain yes/no. If yes, how long? _____
Decreased appetite yes/no. If yes, how long? _____
Vomiting yes/no. If yes, how long? _____
Abdominal pain yes/no. If yes, how long? _____
Rash yes/no. If yes, how long? _____
Joint pain yes/no. If yes, how long? _____
Involuntary muscle twitches (tics) yes/no. If yes, how long? _____
Emotional lability (mood swings) yes/no. If yes, how long? _____
Sleep problems yes/no. If yes, how long? _____

Does your child have any other chronic medical problems? Yes/no. If yes, please explain. _____

Is your child taking other daily prescribed medications? Yes/no. If yes, please explain. _____

Does your child have a medication allergy? Yes/no. What medication/reaction? _____

Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. _____

Does your family have any pets? Yes/no. please circle: dog/cat/other _____

Has your child had any surgeries? Yes/no. If yes, please explain. _____

Does anyone in the family have:

ADD/ADHD ? Yes/no please circle: father/mother/sibling
Learning disabilities? Yes/no please circle: father/mother/sibling
Mental illness (e.g. depression) Yes/no please circle: father/mother/sibling

Does anyone in the family smoke? Yes/no. What is your child's grade in school? _____

Are your child's immunizations up-to-date? Yes/no. If no, please explain. _____

Does your child receive: counseling; speech, occupational or physical therapy? (please circle)

This form completed by: _____ Relationship to Child: _____