PARKSIDE PEDIATRICS

ADHD Appointment Check Up

Tell us how things are going

Today's Date: _____

Patient's Name: _____ Date of Birth _____

Current ADHD Medication Name: _____

Dosage of Medication: _____

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

- ☐ Agitation
- ☐ Anxiety
- ☐ Change of appetite
- ☐ Dizzy
- ☐ Headache
- ☐ Insomnia (trouble sleeping)
- Nausea
- Picking at fingers, nail biting, lip chewing
- Repetitive movements, tics, twitching
- Vomiting
- Heart Pounding
- Extreme sadness or unusual crying

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

_____

_____

_____

_____

_____

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

	Things are great!	Going well	Needs improvement	Terrible – please help!
Home				
School				

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