

**Putnam North Family Medical Center
ADHD Follow-up Information**

Name: _____ Age: _____ Date: _____
 Doctor _____ Medication (Dosage and time taken) _____

Since Last Visit The Following Have... I = Improved, W = Worsened, S = Same	Poorly Controlled	And Now I am Doing (1 2 3 4 5 6 7 8 9 10)	Well Controlled
Target Symptoms:			
Hyperactivity / Restlessness I W S		1 2 3 4 5 6 7 8 9 10	
Attention Span I W S		1 2 3 4 5 6 7 8 9 10	
Distractibility I W S		1 2 3 4 5 6 7 8 9 10	
Finishing Task I W S		1 2 3 4 5 6 7 8 9 10	
Impulse Control I W S		1 2 3 4 5 6 7 8 9 10	
Accepting limits I W S		1 2 3 4 5 6 7 8 9 10	
Peer Relations I W S		1 2 3 4 5 6 7 8 9 10	
School / Work Performance I W S		1 2 3 4 5 6 7 8 9 10	
Side Effects:		1 2 3 4 5 6 7 8 9 10	
Appetite I W S		1 2 3 4 5 6 7 8 9 10	
Moodiness I W S		1 2 3 4 5 6 7 8 9 10	
Abdominal Pain I W S		1 2 3 4 5 6 7 8 9 10	
Dry Mouth I W S		1 2 3 4 5 6 7 8 9 10	

How Long it typically takes you to fall asleep? _____

How many times do you wake up throughout the night? _____

How long do you remain awake each time? _____

Have you experienced and nervous habits or tics? _____

If so, Please explain _____

Describe your eating habits _____

Any other problems? _____

Doctor's Signature

Date