PATIENT ADD QUESTIONNAIRE

Name: _____ Date: _____

Are you doing well? Y___ N___I

Are able to pay attention/focus? Y___ N___

Do you feel like you are eating well? Y___ N___

Are you falling asleep easily? Y___ N___

Do you sleep all night most of the time? Y___ N___

Have you noticed any side effects from the medication?

Stomach ache Y___ N___

Feeling bad Y___ N___

Heart feels funny/racing Y___ N___

Body twitches or tics? Y___ N___

Feeling moody or emotional? Y___ N___

Anything else?

_____

_____

Are your grades fine? Y___ N___

Are you able to finish your homework in a reasonable amount of time? Y___ N___

Is there anything else you think is important to mention?

_____

_____

_____

_____

_____

ADD PARENT QUESTIONNAIRE

Childs Name: _____ Date: _____

Overall, is your child doing well? Y___ N___

Does your child have behavior problems - - at home? Y___ N___

at school? Y___ N___

Does your child have academic problems? Y___ N___

Does your child struggle to complete homework? Y___ N___

Is your child prone to cry easily or to get angry easily? Y___ N___

Is it worse in the evenings? Y___ N___

Do you give medication(s) on the WE? Y___ N___

Does your child have symptoms on the WE? Y___ N___

Do you feel your child sleeps well? Y___ N___

Is your child eating well? Y___ N___

Do you feel like your child feels good about themselves/has a good sense of self confidence? Y___ N___

Please make any comments you feel are important.

_____

_____

_____

_____

_____