ADHD Follow-up Assessment Form

Name________________________ Date____________

1. Do you take the medication everyday as prescribed? YES NO

   If no, how many doses do you take in one week? _______________

   If you are skipping doses of medication, please explain why.

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2. Do you have any side effects since starting medication? YES NO

If yes, explain. ____

3. Do you experience difficulty falling asleep at bedtime? YES NO

4. Do you wake up during the night? YES NO

If yes, how many nights in a week does this happen? ________________

5. Do you notice improvement in tasks at work or school since starting the medication? YES NO

6. Are you less hyperactive while taking this medication? YES NO

7. Do you have a loss of appetite since starting the medication? YES NO

8. Have you had any weight loss since starting the medication? YES NO

9. What time of day you take your medication? _____________

10. Do you take the medication at the same time each day? YES NO

Signature ____________________