Seaside Pediatrics, PA

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ADD/ADHD MEDICATION UPDATE FORM

This form is being completed for ☐a medication refill ☐a medication change ☐a follow-up to a medication change.

Patient name:_____ DOB: _____ Date:_____

Medication:_____ Dose: am_____ mid-day_____ pm_____

School:_____ Grade:_____ Teacher:_____

Remedial services (tutor, therapist, etc.):_____

Since your child's last prescription, these symptoms are:	**Improved**	**Unchanged**	**Worse**
Attention	☐	☐	☐
Distractibility	☐	☐	☐
Frustration level	☐	☐	☐
Impulsivity	☐	☐	☐
Hyperactivity	☐	☐	☐
Accepting limits	☐	☐	☐
Aggression	☐	☐	☐
Self-esteem	☐	☐	☐
Performance in the classroom	☐	☐	☐
Relationships with peers	☐	☐	☐
Relationships with family	☐	☐	☐

Medication side effects:	**Present**	**Absent**
Poor appetite	☐	☐
Weight loss	☐	☐
Sleep problems	☐	☐
Stomachaches	☐	☐
Headaches	☐	☐
"Rebound" later in the day	☐	☐
Sadness	☐	☐
Acting "spacey"	☐	☐
Anxiety	☐	☐
Tics	☐	☐

Overall, are you pleased with your child's current treatment?: **Yes ☐** **No ☐**

If no, what is your biggest concern?: _____

_____