ADHD Medication Check Questionnaire

Date: _____

Name: _____ DOB: _____

Age: _____ Sex: _____ M _____ F Grade in School: _____

School Attending: _____ Private / Public

County Where School is located: _____

How are grades in school? _____

How is conduct in school? _____

Specials concerns at school? _____

_____

How is conduct at home? _____

Any special concerns at home? _____

_____

Present Medication and Dose: _____

_____

How long on this dose? _____

Problems or concerns about medication at present? _____

Currently seeing any other Doctor or Therapist? _____ Yes _____ No

Name: _____

For what? _____

How long? _____

Any special medical concerns today? _____

List extracurricular activities, hobbies, interests, etc. _____

_____

Any other comments: _____

_____