Child's Name Today's Date

SECTION TO BE COMPLETED BY PARENT

Please rate the following on a scale of 0-3 (not true to very true)

Restless or overactive	0	1	2	3
Excitable or impulsive	0	1	2	3
Fails to finish things he/ she starts	0	1	2	3
Inattentive or easily distracted	0	1	2	3
Temper outbursts	0	1	2	3
Fidgeting	0	1	2	3
Disturbs other children	0	1	2	3
Demands must be met immediately-easily frustrated	0	1	2	3
Cries often and easily	0	1	2	3
Mood changes quickly and drastically	0	1	2	3

Please rate the following:

Appetite	Good	Fair	Poor	Improved
Sleep	Good	Fair	Poor	Improved
GI upset	Good	Fair	Poor	Improved
Headache	Good	Fair	Poor	Improved
Tremors	Good	Fair	Poor	Improved
Rebound	Good	Fair	Poor	Improved
Mood	Good	Fair	Poor	Improved
Compliance	Good	Fair	Poor	Improved
Duration of efficacy	Good	Fair	Poor	Improved

Please rate the following on a scale 1-5 (poor to excellent)

Attention at school	1	2	3	4	5
Attention at home	1	2	3	4	5
Hyperactivity	1	2	3	4	5
Impulsivity	1	2	3	4	5
Forgetfulness	1	2	3	4	5
Distractibility	1	2	3	4	5
Organization	1	2	3	4	5
Home assessment	1	2	3	4	5
School behavior	1	2	3	4	5
After school activities	1	2	3	4	5
Social interactions	1	2	3	4	5
Family participation	1	2	3	4	5
Disruptive behaviors	1	2	3	4	5
Accidents/ Injuries	1	2	3	4	5

Other Concerns/ Comments:

TO BE COMPLETED BY DOCTOR/NURSE

Name DoB / / Seen with: Mth Fth Other Rm

GDS	S	T
1		
2		
3		
4		
5		
6		
7		
8		
9		
0		

Previous Meds: **Current Meds:** **Drug Allergies:** Y N

G	Nk	Ext
Ey	L	Nr
E	H	S
N	A	
M	G/R	

Other Diagnosis: New Pt. WCC Level_____

Procedures

B Behavior	Date	Time	Age	Weight	%	Height	%	B/P	Temp	Insurance