Patient Name: _____ Date: _____

ADHD/ADD Reassessment

Questionnaire for: Parents of Children with ADHD/ADD

This questionnaire is intended to assist in reassessing the treatment plan for your pediatric patient with ADHD/ADD, in conjunction with a full clinical evaluation.

- **What time does your child take his/her medication in the morning? _____AM**

- **What time do ADHD/ADD symptoms reappear? _____AM or PM**

  What symptoms does your child experience at this time? _____
  _____
  _____

- **Are your child's ADHD/ADD symptoms controlled during after-school activities, including homework time?**
  □ YES □ NO

  If not, what ADHD/ADD Symptoms are not adequately controlled during this time?
  _____
  _____

- **Are your child's ADHD/ADD symptoms controlled consistently through out the day?**
  □ YES □ NO

- **Do you feel that your child's ADHD/ADD symptoms are well controlled with his/her current ADHD/ADD treatment plan?**
  □ YES □ NO

- **Do you feel that your child's current ADHD/ADD medication is well tolerated?**
  □ YES □ NO

Notes: _____
_____