ADHD Follow-Up Assessment Form

Name: ______________________________________ Date: _____________________

1) Do you take the medication every day as prescribed? YES or NO

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

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

   ____

   ___

2) Do you have any side effects since starting the medication? YES or NO

   If yes, explain: ____

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

4) Do you wake up during the night? YES or 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 or NO

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

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

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

9) What time of the day you take your medication? ___________________________

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

Signature: ____