Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

ADHD FOLLOW-UP SELF-REPORT

Name: _____ Date of Birth: _____

Today's Date: _____ Your Phone Number: _____

- Are your ADHD symptoms controlled consistently throughout the day? ❑ Yes ❑ No
- If you are currently taking ADHD medication, how long does it control your symptoms? _____ Hours.
- Are your ADHD symptoms controlled during after-school/work hours including homework time? ❑ Yes ❑ No
- If not, what ADHD symptoms are not adequately controlled during this time? _____

  _____
- Do you feel that you need more symptom control than what is provided by your current ADHD treatment plan? ❑ No ❑ Yes
- Do you feel that your current or prior ADHD medication is/was well tolerated? ❑ Yes ❑ No

SYMPTOMS WHILE ON MEDICATIONS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. I do not pay attention to details, make careless mistakes on homework or other work.	0	1	2	3
2. I have difficulty paying attention to what needs to be done.	0	1	2	3
3. I do not listen well when spoken to directly.	0	1	2	3
4. I do not follow through when given directions and fail to finish activities.	0	1	2	3
5. I have difficulty organizing tasks and activities.	0	1	2	3
6. I avoid, dislike, or do not want to start tasks that require ongoing mental effort.	0	1	2	3
7. I lose things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. I am easily distracted by noises or other stimuli.	0	1	2	3
9. I am forgetful in daily activities.	0	1	2	3
10. I fidget and squirm a lot.	0	1	2	3
11. I have trouble remaining seated when it is expected.	0	1	2	3
12. I am agitated and restless.	0	1	2	3
13. I have difficulty engaging in leisurely activities quietly.	0	1	2	3
14. I am "on the go" and have a hard time relaxing.	0	1	2	3
15. I talk too much.	0	1	2	3
16. I blurt out answers before questions have been completed.	0	1	2	3
17. I have difficulty waiting my turn in conversations, activities, or driving.	0	1	2	3
18. I interrupt or intrude in on others' conversations and/or activities.	0	1	2	3
19. I argue with others often.	0	1	2	3
20. I lose my temper.	0	1	2	3
21. I actively defy or refuse to go along with others' requests and/or activities.	0	1	2	3
22. I deliberately annoy people	0	1	2	3
23. I blame others for my mistakes or misbehavior.	0	1	2	3
24. I am touchy or easily annoyed by others.	0	1	2	3
25. I am angry or resentful.	0	1	2	3
26. I am spiteful and want to get even.	0	1	2	3
27. I am fearful, anxious, or worried.	0	1	2	3
28. I am afraid to try new things for fear of making mistakes.	0	1	2	3
29. I feel worthless or inferior.	0	1	2	3
30. I blame myself for problems, feel guilty.	0	1	2	3
31. I feel lonely, unwanted, or unloved; complain that "no one loves me."	0	1	2	3
32. I am sad, unhappy, or depressed.	0	1	2	3
33. I am self-conscious or easily embarrassed.	0	1	2	3

Continued on Reverse

Name: _____ Date of Birth: _____

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
34. Overall school/work performance	1	2	3	4	5
35. Reading	1	2	3	4	5
36. Math	1	2	3	4	5
37. Writing	1	2	3	4	5
38. Relationships with parents.	1	2	3	4	5
39. Relationships with siblings.	1	2	3	4	5
40. Relationships with peers.	1	2	3	4	5
41. Relationship with spouse/significant other.	1	2	3	4	5

Side Effects: Have you experienced any of the following side effects or problems in the past week?	NONE	MILD	MODERATE	SEVERE
Change of appetite	0	1	2	3
Weight loss	0	1	2	3
Trouble sleeping	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Chest pain	0	1	2	3
Stomachache	0	1	2	3
Headache	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, eye blinking	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek chewing	0	1	2	3
Irritability in the late morning, late afternoon, or evening	0	1	2	3
Problem behaviors when medications are wearing off	0	1	2	3
Excessive worrying, anxiety	0	1	2	3
Sees or hears things that aren't there	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dizziness	0	1	2	3
Skin rash	0	1	2	3

COMMENTS:

For Office Use Only

Inattention 1-9: _____/9 Hyp-Imp 10-18: _____/9 ODD 19-26: _____/8 Dep / Anx 27-33 _____/7

Strengths: Weaknesses:

Provider Initials:_____

Children's MINNESOTA

Patient Health Questionnaire - PHQ 9

Instructions: How often have you been bothered by each of the following symptoms during the *last two weeks*? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling asleep or staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like reading the newspaper or watching television?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

FOR OFFICE CODING _____ + _____ + _____ + _____

=Total Score: _____

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Date completed: _____

PLACE PATIENT LABEL HERE

Source: PHQ-9(Author Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

Children's MINNESOTA

Generalized Anxiety Disorder 7 – Item (GAD-7) Scale

Instructions: Over the last 2 weeks, how often have you been bothered by the following problems?	(0) Not at All	(1) Several Days	(2) Over Half the Days	(3) Nearly Every Day
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Add score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Date completed: _____

PLACE PATIENT LABEL HERE