DELAWARE PEDIATRICS
ADHD CARE ASSESSMENT

Patient Name: ___________________________ DOB: _____________

Current ADHD Medication: ________________________________

Is medication working well? ☐ Yes ☐ No

Takes Medication: ☐ Everyday ☐ School days only

Grades compared to previous report:

☐ Failing ☐ Declining ☐ No change

☐ Improving ☐ Significantly improved

Which area below would you choose to make improvements?

☐ Bedtime habits ☐ Behavior ☐ School/Time management

☐ Organizations ☐ Other

What do you think prevents you from making changes?

☐ No Barriers ☐ No interest from child ☐ Busy Lifestyle

☐ Lack of Resources ☐ Other

Signature of person completing form: _____________________________ Date: ____________

Signature of Provider: ____ Date: _____________