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: _________________________