MACK PEDIATRICS

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ADHD Prescription Pick-Up Form

Patient Name:_____ Date of Birth:____/____/_____
Date of Form Completion:____/____/_____
Form completed by: _____

Medications (list all ADHD medications, including dose and time(s) of day taken):

1.
2.
3.

Please mark any side effects your child has from the medication:

___fatigue/sedation ___mood disturbance ___tics ___decreased appetite ___frequent headaches ___nausea___inappropriate behavior ___interpersonal relationship problems with peers/siblings ___stomachaces ___weight loss ___ insomnia ___tremors ___picking at skin/nails ___nail-biting

Please explain provide more information about any side effects:

Please list any concerns that you or the teacher have about your child's ADHD:

Are you concerned about your child's school performance? No__ Yes___. If yes, please explain.

Are you concerned about your child's behavior at home or school? No__ Yes___. If yes, please explain.

Do you keep track of your child's school progress (by communication with teacher or through the school's website)? No__ Yes___

Does your child have an IEP or 504 Plan in place at school? No__ Yes___

If yes, please list modifications in place:

Does your child see any other clinicians (psychologist, counselor, therapist, etc.)? No__ Yes___

If yes, please list that person's name: