South Carolina PLAY
Project to **L**earn about **A**DHD in **Y**outh

ID Number | | | | | | |

OMB No: ???: Exp Date: ???

ADHD Treatment, Cost, and Client Satisfaction Questionnaire

ADHD Treatment

1. Has your child been diagnosed with any of the following? (Select all that apply)

- O social phobia
- O generalized anxiety
- O tics
- O obsessive compulsive disorder
- O separation anxiety
- O mutism
- O pica
- O conduct disorder
- O specific phobia
- O obsessive compulsive disorder
- O trichotillomania
- O other
- O panic disorder
- O post traumatic stress disorder
- O depression
- O attention deficit hyper-activity disorder
- O agoraphobia
- O elimination disorder
- O mania

If you selected ADHD (attention deficit hyper-activity disorder) above please complete the remaining form.

2. When was your child diagnosed with ADHD? Month Year
O NA
O Don't Know

2a. Who diagnosed your child with ADHD? Name Profession:
O Not applicable
O Missing/ Don't Know

2b. Where (city) is this professional located?

3. Are you affiliated with a support group for your child's condition?
O No
O Yes

If yes, please list support groups:

4. Has your child received medication as part of his/her treatment in the past 12 months*?*
O No
O Yes

If No, Go To Question 5

4a. If yes, was any of the cost covered by insurance?
O No
O Yes

4b. (enter average **monetary** cost) $

4c. Who administers the medication to your child? **Select all that apply**
O Parent
O School Nurse/Personnel/Other
O Child

4d. How many medications has your child taken in the past 12 months? ☐
Please list below:

Medication 1:	**Medication 2:**
☐	☐
Start Date ☐ ☐ ☐ Month Day Year	Start Date ☐ ☐ ☐ Month Day Year
End Date ☐ ☐ ☐ Month Day Year	End Date ☐ ☐ ☐ Month Day Year
Dosage:	Dosage:
O 1 x day O 2 x daily O 3 x daily O 5 days/wk O 7 days/wk	O 1 x day O 2 x daily O 3 x daily O 5 days/wk O 7 days/wk
How many mg per day? ☐	How many mg per day? ☐
Is this the prescribed amount?	Is this the prescribed amount?
O Yes O No, child is taking more O No, child is taking less	O Yes O No, child is taking more O No, child is taking less
What was the cost to you? $ ☐	What was the cost to you? $ ☐
Does your child take this medication in the summer?	Does your child take this medication in the summer?
O No O Yes	O No O Yes
For what problem was the medication given?	For what problem was the medication given?
☐	☐
Do you think the medication helped?	Do you think the medication helped?
O No O Yes	O No O Yes

Why did he/she stop?

Medication 3:

Start Date ☐☐ ☐☐ ☐☐
Month Day Year

End Date ☐☐ ☐☐ ☐☐
Month Day Year

Dosage:

O 1 x day
O 2 x daily
O 3 x daily
O 5 days/wk
O 7 days/wk

How many mg per day? ☐☐☐

Is this the prescribed amount?

O Yes
O No, child is taking more
O No, child is taking less

What was the cost to you? $ ☐☐☐☐

Does your child take this medication in the summer?

O No
O Yes

For what problem was the medication given?

Do you think the medication helped?

O No
O Yes

Why did he/she stop?

Medication 4:

Start Date ☐☐ ☐☐ ☐☐
Month Day Year

End Date ☐☐ ☐☐ ☐☐
Month Day Year

Dosage:

O 1 x day
O 2 x daily
O 3 x daily
O 5 days/wk
O 7 days/wk

How many mg per day? ☐☐☐

Is this the prescribed amount?

O Yes
O No, child is taking more
O No, child is taking less

What was the cost to you? $ ☐☐☐☐

Does your child take this medication in the summer?

O No
O Yes

For what problem was the medication given?

Do you think the medication helped?

O No
O Yes

Why did he/she stop?	Why did he/she stop?

5. Has your child taken dietary supplements (vitamins and/or herbs) as part of his/her treatment in the past 12 months?

O No
O Yes

If No, Go To Question 6

5a. If yes, How many? ☐

5b. What was the cost to you? (enter average **monetary** cost) $ ☐

5c. Please list (zinc, chamomile, kava hops, lemon balm, valerian root, passionflower, melatonin, ginko biloba, pycnogenol, nystatin, ketonazole, piracetam, dimethylaminoethanol, linoleic, linolenic acids, megavitamins):

Vitamin 1: ☐	**Vitamin 3:** ☐
How many mg per day? ☐	How many mg per day? ☐
Vitamin 2: ☐	**Vitamin 4:** ☐
How many mg per day? ☐	How many mg per day? ☐

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6. In the past year, have **you** received **parent training** as related to the child's treatment? (parent training includes: counseling, behavior modification training, or other parent training)

O No
O Yes

If No, Go To Question 7

6a. If yes, Provided by:

O School
O Mental Health Provider
O Physician / Pediatrician
O Other

6b. Was it for:

O ADHD
O Other _____

6c. Number of times ☐ hours ☐

6d. Was any of the cost covered by insurance?

O No
O Yes

6e. What was the cost to you? (enter average **monetary** cost) $ ☐

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7. In the past 12 months, has **your child** received **social skills training** as related to his/her treatment?

O No
O Yes

If No, Go To Question 8

7a. If yes, Provided by:

O School
O Mental Health Provider
O Physician / Pediatrician
O Other

7b. Was it for:
- O ADHD
- O Other _____

7c. Number of times ☐ hours ☐

7d. Was any of the cost covered by insurance?
- O No
- O Yes

7e. What was the cost to you? (enter average **monetary** cost) $ ☐

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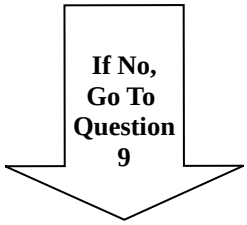
8. In the past 12 months, has **your child** received **school or classroom programs** as related to his/her treatment? (school or classroom programs include: classroom modifications, preferential seating, testing accommodations, and behavior management plans applied in the classroom or school)
- O No
- O Yes



8a. If yes, Provided by:
- O Teacher
- O School Counselor/Psychologist
- O Other _____

8b. Was it for:
- O ADHD
- O Other _____

8c. Number of times ☐ hours ☐

8d. Was any of the cost covered by insurance?
- O No
- O Yes

8e. What was the cost to you? (enter average **monetary** cost) $ ☐

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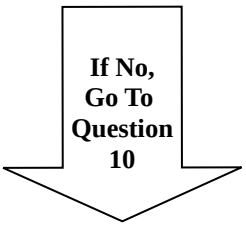
9. In the past 12 months, has **your child** received **counseling** as related to his/her treatment?
- O No
- O Yes



9a. If yes, Provided by:
- O School
- O Mental Health Provider
- O Physician / Pediatrician
- O Other

9b. Was it for:
- O ADHD
- O Other _____

9c. Number of times ☐ hours ☐

9d. Type:
- O Individual
- O Group

9e. Was any of the cost covered by insurance?
- O No
- O Yes

9f. What was the cost to you? (enter average **monetary** cost) $ ☐

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10. In the past year, has **your child** made **dietary changes** as related to the child's treatment?
- O No
- O Yes

If No, Go To Question 11

10a. If yes, Provided by:
- O School
- O Mental Health Provider
- O Physician / Pediatrician
- O Other

10b. Time on diet (months) ☐

10c. Was it for:
- O ADHD
- O Other _____

10d. Type of diet ☐

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11. In the past year, has **your child** received **"alternative" services** (i.e. EEG biofeedback or sensory integration) as related to his/her treatment?
- O No
- O Yes

If No, Go To Next Section

11a. If yes, list below:

☐

11b. Provided by:
- O School
- O Mental Health Provider
- O Physician / Pediatrician
- O Other

11c. Number of times ☐ hours ☐

11d. Was any of the cost covered by insurance?
- O No
- O Yes

11e. What was the cost to you? (enter average **monetary** cost) $ ☐

This section for Annual Assessments Only

MEDICATIONS	
1. In the past 12 months, has your child ever used too much of his/her medication? **(If NO, go to question 2)**	O Yes O No
a. If yes, did he/she have to get medical care?	O Yes O No
b. If yes, did he/she have to go to the emergency room?	O Yes O No
2. In the past 12 months, has your child ever stopped taking his/her medication because of a side effect or negative reaction?	O Yes O No
TREATMENT COSTS	
3. During the past 12 months, how much has your family paid out-of-pocket for your child's health related needs?	O Nothing, $0 O Less than $250 O $250-$500 O More than $500
4. Did you ever stop a treatment or decide not to buy a medication for your child's condition because it was too expensive?	O Yes O No
5. Has your child's health condition(s) caused financial problems for the family?	O Yes O No
6. How many hours a month do you or other family members spend taking your child to the doctor or to receive treatments, counseling, training, etc.?	☐ hours
Note: Please answer the next 4 questions if your child is currently covered by some form of health insurance.	
7. Does your child's health insurance offer benefits that meet his/her needs?	O Never O Sometimes O Usually O Always
8. Are the costs not covered by your child's health insurance reasonable?	O Never O Sometimes O Usually O Always
9. Does the health insurance company allow your child to see the health care providers he/she needs?	O Never O Sometimes O Usually O Always

10. Does the health insurance company cover all the treatments recommended by your doctor or health care provider?	O Never O Sometimes O Usually O Always

CSQ-8: Now we would like to learn how satisfied you have been with the services your child has received in the last twelve months: Please respond to each category of treatment you or your child has received.			
	Medical Services	**Psychological/ Behavioral**	**School Services**
1. How would you rate the quality of service your child has received?	O Poor O Fair O Good O Excellent	O Poor O Fair O Good O Excellent	O Poor O Fair O Good O Excellent
2. Did your child get the kind of service you wanted?	O No, definitely not O No, not really O Yes, generally O Yes, definitely	O No, definitely not O No, not really O Yes, generally O Yes, definitely	O No, definitely not O No, not really O Yes, generally O Yes, definitely
3. To what extent has this service met your child's needs?	O None of my child's needs have been met O Only a few of my child's needs have been met O Most of my child's needs have been met O Almost all of my child's needs have been met	O None of my child's needs have been met O Only a few of my child's needs have been met O Most of my child's needs have been met O Almost all of my child's needs have been met	O None of my child's needs have been met O Only a few of my child's needs have been met O Most of my child's needs have been met O Almost all of my child's needs have been met
4. If a friend were in need of similar help, would you recommend this service to his or her family?	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely
5. How satisfied are you with the amount of help your child has received?	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied
6. Have the services your child received helped him/her to deal more effectively with problems?	O No, they seemed to make things worse O No, they really didn't help O Yes, they helped somewhat O Yes, they helped a great deal	O No, they seemed to make things worse O No, they really didn't help O Yes, they helped somewhat O Yes, they helped a great deal	O No, they seemed to make things worse O No, they really didn't help O Yes, they helped somewhat O Yes, they helped a great deal
7. In an overall, general sense, how satisfied are you with the service your child has received?	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied	O Quite dissatisfied O Indifferent/mildly satisfied O Mostly satisfied O Very satisfied
8. If you were to seek help for your child again, would you return to this service?	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely	O No, definitely not O No, I don't think so O Yes, I think so O Yes, definitely