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

ID Number | | | | | | |

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

ADHD Treatment Quarterly Update

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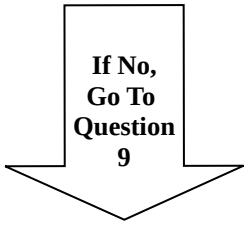
8. In the past 12 months, has **your child** received **school or classroom programs** as related to his/her treatment? (school or classroom programs include: classroom modifications, preferential seating, testing accommodations, and behavior management plans applied in the classroom or school)
- O No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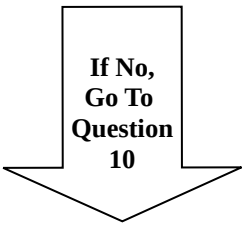
9. In the past 12 months, has **your child** received **counseling** as related to his/her treatment?
- O No
- O Yes



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 Form

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) $ ☐