



South Carolina **PLAY**
Project to Learn about ADHD in Youth

ID
Number

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OMB No.: 0920-0747; Exp Date: ???

ADHD Treatment Quarterly Update

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

- | | |
|---|---|
| <input type="radio"/> social phobia | <input type="radio"/> trichotillomania |
| <input type="radio"/> generalized anxiety | <input type="radio"/> other |
| <input type="radio"/> tics | <input type="radio"/> panic disorder |
| <input type="radio"/> obsessive compulsive disorder | <input type="radio"/> post traumatic stress disorder |
| <input type="radio"/> separation anxiety | <input type="radio"/> depression |
| <input type="radio"/> mutism | <input type="radio"/> attention deficit hyper-activity disorder |
| <input type="radio"/> pica | <input type="radio"/> agoraphobia |
| <input type="radio"/> conduct disorder | <input type="radio"/> elimination disorder |
| <input type="radio"/> specific phobia | <input type="radio"/> mania |

If you selected ADHD (attention deficit/hyperactivity disorder) above please complete the remaining form.

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

- 2a. Who diagnosed your child with ADHD? Name Profession:
- ☐ Not applicable
- ☐ Don't Know

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

3. Are you affiliated with a support group for your child's condition?

- ☐ No
- ☐ Yes

If yes, please list support groups:

4. Has your child received medication as part of his/her treatment in the past 12 months?

- ☐ No
- ☐ Yes

4a. If yes, was any of the cost covered by insurance?

- ☐ No
- ☐ Yes

4b. (enter average **monthly** cost) \$

4c. Who administers the medication to your child? **Select all that apply**

- ☐ Parent
- ☐ School Nurse/Personnel/Other
- ☐ Child

**If No,
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4d. How many medications has your child taken in the past 12 months?

Please list below:

Medication 1:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

Why did he/she stop?

Medication 2:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

Why did he/she stop?

Medication 3:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

Why did he/she stop?

Medication 4:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

Why did he/she stop?

Medication 5:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

Why did he/she stop?

Medication 6:

Start Date
Month Day Year

End Date
Month Day Year

Dosage:

- ☐ 1 x day
☐ 2 x daily
☐ 3 x daily
☐ 5 days/wk
☐ 7 days/wk

How many mg per day?

Is this the prescribed amount?

- ☐ Yes
☐ No, child is taking more
☐ No, child is taking less

What was the cost to you? \$

Does your child take this medication in the summer?

- ☐ No
☐ Yes

For what problem was the medication given?

Do you think the medication helped?

- ☐ No
☐ Yes

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?

- ☐ No
☐ Yes

If No,
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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:

How many mg per day?

Vitamin 2:

How many mg per day?

Vitamin 3:

How many mg per day?

Vitamin 4:

How many mg per day?

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)

- ☐ No
☐ Yes

If No,
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6a. If yes, Provided by:

- ☐ School
☐ Mental Health Provider
☐ Physician / Pediatrician
☐ Other

6b. Was it for:

- ☐ ADHD
☐ Other _____

6c. Number of times hours

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

- ☐ No
☐ Yes

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

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

- ☐ No
☐ Yes

If No,
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Question
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7a. If yes, Provided by:

- ☐ School
☐ Mental Health Provider
☐ Physician / Pediatrician
☐ Other

7b. Was it for:

- ☐ ADHD
- ☐ Other _____

7c. Number of times hours

7d. Was any of the cost covered by insurance?

- ☐ No
- ☐ Yes

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

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)

- ☐ No
- ☐ Yes

8a. If yes, Provided by:

- ☐ Teacher
- ☐ School Counselor/Psychologist
- ☐ Other _____

8b. Was it for:

- ☐ ADHD
- ☐ Other _____

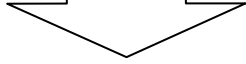
8c. Number of times hours

8d. Was any of the cost covered by insurance?

- ☐ No
- ☐ Yes

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

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

- ☐ No
- ☐ Yes

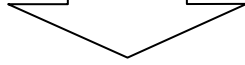
9a. If yes, Provided by:

- ☐ School
- ☐ Mental Health Provider
- ☐ Physician / Pediatrician
- ☐ Other

9b. Was it for:

- ☐ ADHD
- ☐ Other _____

**If No,
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9c. Number of times hours

9d. Type:

- ☐ Individual
- ☐ Group

9e. Was any of the cost covered by insurance?

- ☐ No
- ☐ Yes

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

10. In the past year, has **your child** made **dietary changes** as related to the child's treatment?

- ☐ No
- ☐ Yes

10a. If yes, Provided by:

- ☐ School
- ☐ Mental Health Provider
- ☐ Physician / Pediatrician
- ☐ Other

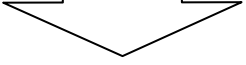
10b. Time on diet (months)

10c. Was it for:

- ☐ ADHD
- ☐ Other

10d. Type of diet

If No,
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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?

- ☐ No
- ☐ Yes

11a. If yes, list below:

11b. Provided by:

- ☐ School
- ☐ Mental Health Provider
- ☐ Physician / Pediatrician
- ☐ Other

11c. Number of times hours

11d. Was any of the cost covered by insurance?

- ☐ No
- ☐ Yes

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

If No,
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