

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

ID  
Number

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OMB No: 0920-0747: 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)

- |                                                     |                                                                 |
|-----------------------------------------------------|-----------------------------------------------------------------|
| <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?    
☐ NA Month Year  
☐ 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,  
Go To  
Question  
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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 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?

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,  
Go To  
Question  
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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,  
Go To  
Question  
7

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,  
Go To  
Question  
8

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 \_\_\_\_\_

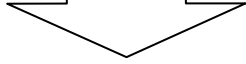
**8c.** Number of times  hours

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

- ☐ No
- ☐ Yes

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

**If No,  
Go To  
Question  
9**



**9.** In the past 12 months, has **your child** received **counseling** as related to his/her treatment?

- ☐ No
- ☐ Yes

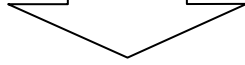
**9a.** If yes, Provided by:

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

**9b.** Was it for:

- ☐ ADHD
- ☐ Other \_\_\_\_\_

**If No,  
Go To  
Question  
10**



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

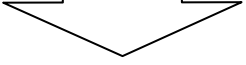
10b. Time on diet (months)

10c. Was it for:

- ☐ ADHD
- ☐ Other

10d. Type of diet

If No,  
Go To  
Question  
11



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,  
Go To  
Next  
Section



**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) ☐ Yes  
☐ No

a. If yes, did he/she have to get medical care? ☐ Yes  
☐ No

b. If yes, did he/she have to go to the emergency room? ☐ Yes  
☐ No

**2.** In the past 12 months, has your child ever stopped taking his/her medication because of a side effect or negative reaction? ☐ Yes  
☐ 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? ☐ Nothing, \$0  
☐ Less than \$250  
☐ \$250-\$500  
☐ 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? ☐ Yes  
☐ No

**5.** Has your child's health condition(s) caused financial problems for the family? ☐ Yes  
☐ 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? ☐ Never  
☐ Sometimes  
☐ Usually  
☐ Always

**8.** Are the costs not covered by your child's health insurance reasonable? ☐ Never  
☐ Sometimes  
☐ Usually  
☐ Always

**9.** Does the health insurance company allow your child to see the health care providers he/she needs? ☐ Never  
☐ Sometimes  
☐ Usually  
☐ Always

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

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

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