



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

ID
Number

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?

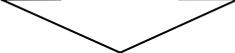
- No
- Yes

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
6



5a. If yes, How many?

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

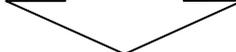
5c. Please list (zinc, chamomile, kava hops, lemon balm, valerian root, passionflower, melatonin, ginko biloba, pycnogenol, nystatin, ketonazole, piracetam, dimethylaminoethanol, linoleic, linolenic acids, megavitamins):

Vitamin 1: <input type="text"/>	Vitamin 3: <input type="text"/>
How many mg per day? <input type="text"/>	How many mg per day? <input type="text"/>
Vitamin 2: <input type="text"/>	Vitamin 4: <input type="text"/>
How many mg per day? <input type="text"/>	How many mg per day? <input type="text"/>

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
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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?

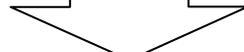
- No
- Yes

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,
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 _____

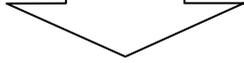
8c. Number of times hours

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

- No
- Yes

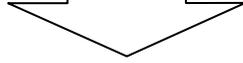
9a. If yes, Provided by:

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

9b. Was it for:

- ADHD
- Other _____

**If No,
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

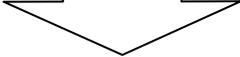
10b. Time on diet (months)

10c. Was it for:

- ADHD
- Other _____

10d. Type of diet

If No,
Go To
Question
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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

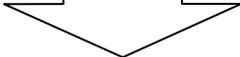
11c. Number of times hours

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

- No
- Yes

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

If No,
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)	<input type="radio"/> Yes <input type="radio"/> No
a. If yes, did he/she have to get medical care?	<input type="radio"/> Yes <input type="radio"/> No
b. If yes, did he/she have to go to the emergency room?	<input type="radio"/> Yes <input type="radio"/> No
2. In the past 12 months, has your child ever stopped taking his/her medication because of a side effect or negative reaction?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Nothing, \$0 <input type="radio"/> Less than \$250 <input type="radio"/> \$250-\$500 <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No
5. Has your child's health condition(s) caused financial problems for the family?	<input type="radio"/> Yes <input type="radio"/> 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.?	<input type="text"/> 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?	<input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Usually <input type="radio"/> Always
8. Are the costs not covered by your child's health insurance reasonable?	<input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Usually <input type="radio"/> Always
9. Does the health insurance company allow your child to see the health care providers he/she needs?	<input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Usually <input type="radio"/> Always
10. Does the health insurance company cover all the treatments recommended by your doctor or health care provider?	<input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Usually <input type="radio"/> 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?	<input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent	<input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent	<input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Excellent
2. Did your child get the kind of service you wanted?	<input type="radio"/> No, definitely not <input type="radio"/> No, not really <input type="radio"/> Yes, generally <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, not really <input type="radio"/> Yes, generally <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, not really <input type="radio"/> Yes, generally <input type="radio"/> Yes, definitely
3. To what extent has this service met your child's needs?	<input type="radio"/> None of my child's needs have been met <input type="radio"/> Only a few of my child's needs have been met <input type="radio"/> Most of my child's needs have been met <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 <input type="radio"/> Only a few of my child's needs have been met <input type="radio"/> Most of my child's needs have been met <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 <input type="radio"/> Only a few of my child's needs have been met <input type="radio"/> Most of my child's needs have been met <input type="radio"/> 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?	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely
5. How satisfied are you with the amount of help your child has received?	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied
6. 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 <input type="radio"/> No, they really didn't help <input type="radio"/> Yes, they helped somewhat <input type="radio"/> Yes, they helped a great deal	<input type="radio"/> No, they seemed to make things worse <input type="radio"/> No, they really didn't help <input type="radio"/> Yes, they helped somewhat <input type="radio"/> Yes, they helped a great deal	<input type="radio"/> No, they seemed to make things worse <input type="radio"/> No, they really didn't help <input type="radio"/> Yes, they helped somewhat <input type="radio"/> Yes, they helped a great deal
7. In an overall, general sense, how satisfied are you with the service your child has received?	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied	<input type="radio"/> Quite dissatisfied <input type="radio"/> Indifferent/mildly satisfied <input type="radio"/> Mostly satisfied <input type="radio"/> Very satisfied
8. If you were to seek help for your child again, would you return to this service?	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely	<input type="radio"/> No, definitely not <input type="radio"/> No, I don't think so <input type="radio"/> Yes, I think so <input type="radio"/> Yes, definitely

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