



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

ID
Number

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?

- 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
5**

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA ???).

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?

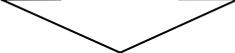
- No
- Yes

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,
Go To
Question
6



5a. If yes, How many?

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

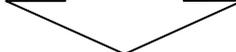
5c. Please list (zinc, chamomile, kava hops, lemon balm, valerian root, passionflower, melatonin, ginko biloba, pycnogenol, nystatin, ketonazole, piracetam, dimethylaminoethanol, linoleic, linolenic acids, megavitamins):

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
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?

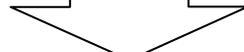
- No
- Yes

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 _____

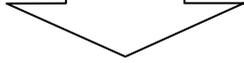
8c. Number of times hours

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

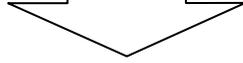
9a. If yes, Provided by:

- 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

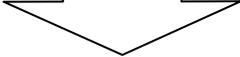
10b. Time on diet (months)

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
Form

