



Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

CADDRA CLINICIAN ADHD BASELINE/FOLLOW-UP FORM

Patient Name: _____		Date of Birth: _____		Date seen: _____		
Other person present during interview: _____						
Clinician:			Other therapist(s) involved:			
Current medication(s):	Dose & schedule	Therapeutic Effects	Side Effects			
Adherence to treatment (took medications as directed)						
<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL (missed doses, did not take all medication) <input type="checkbox"/> NONE (Discontinued medication for at least a week)						
Developments since last appointment:						
Height:	Weight:	BP:	Pulse:	Observations:		
Opinion						
Axis I	<input type="checkbox"/> ADHD, Combined	<input type="checkbox"/> Oppositional Defiant	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Learning Disorder	
	<input type="checkbox"/> ADHD, Inattentive	<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Tic Disorder	<input type="checkbox"/> Language Disorder	<input type="checkbox"/> Other	
Axis II	<input type="checkbox"/> Personality Disorder <input type="checkbox"/> Mental retardation					
Axis III (physical abnormalities)						
Axis IV	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme	Axis V (Clinical Global Assessment of Functioning 1-100)	
Impairment Severity	<input type="checkbox"/> Borderline	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
<input type="checkbox"/> Very much improved	<input type="checkbox"/> Much improved	<input type="checkbox"/> Minimally improved	<input type="checkbox"/> No change	<input type="checkbox"/> Minimally worse	<input type="checkbox"/> Much worse	<input type="checkbox"/> Very much worse
Treatment Plan						
Medication:	<input type="checkbox"/> No change <input type="checkbox"/> Decrease <input type="checkbox"/> Increase <input type="checkbox"/> Switch					
Psychological/Other:						
School/work:						
Follow-up plan:						
Signature:			Date:			
<input type="checkbox"/> Copy to be sent to:						