CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

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)
☐ FULL ☐ PARTIAL (missed doses, did not take all medication) ☐ NONE (Discontinued medication for at least a week)

Developments since last appointment:

Height: Weight: BP: Pulse: Observations:

Opinion

Axis I
☐ ADHD, Combined ☐ Oppositional Defiant ☐ Anxiety Disorder ☐ Depression ☐ Learning Disorder
☐ ADHD, Inattentive ☐ Conduct Disorder ☐ Tic Disorder ☐ Language Disorder ☐ Other

Axis II ☐ Personality Disorder ☐ Mental retardation

Axis III (physical abnormalities)

Axis IV ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme Axis V (Clinical Global Assessment of Functioning 1-100)

Impairment Severity	☐ Borderline	☐ Mild	☐ Moderate	☐ Marked	☐ Severe	☐ Extreme
☐ Very much improved	☐ Much improved	☐ Minimally improved	☐ No change	☐ Minimally worse	☐ Much worse	☐ Very much worse

Treatment Plan

Medication: ☐ No change ☐ Decrease ☐ Increase ☐ Switch

Psychological/Other:

School/work:

Follow-up plan:

Signature: Date:

☐ Copy to be sent to: