CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name: _____

Date of birth: _____ **MRN/File #:** _____

Clinician's Name: _____ **Date:** _____

CADDRA PATIENT ADHD MEDICATION FORM

Please complete and bring to your next appointment

CURRENT MEDICATIONS List all current medications here:

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

Please mark any changes that have occurred since taking the current medication on the lines below:

ADHD Symptom Control

-3	-2	-1	0	1	2	3
worse			unchanged			better

Tolerability of Medication (side effects)

-3	-2	-1	0	1	2	3
worse			unchanged			better

Quality of Life

-3	-2	-1	0	1	2	3
worse			unchanged			better

How would you rate the global changes that have occurred since medication started?

- ☐ Not applicable (medication not taken)
- ☐ Marked improvement
- ☐ Small improvement
- ☐ No change
- ☐ Small deterioration
- ☐ Marked deterioration

Comments:

_____

_____

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Please mark with an X the frequency of any side effects experienced with the current treatment since your last medical appointment. Contact your physician if side effects are significant.

SIDE EFFECT	FREQUENCY				
	Not at all	*Sometimes*	*Often*	*All the time*	*Comments*
Appetite reduction					
Weight loss					
Weight gain					
Stomach aches					
Nausea					
Vomiting					
Diarrhea					
Dryness (skin/ eyes/ mouth)					
Thirst					
Sore throat					
Sleep difficulties					
Tics					
Headache					
Muscular tensions					
Fatigue					
Dizziness					
Sweating					
Agitation/excitability					
Irritability					
Mood instability					
Over focus “zombie effect”					
Sadness					
Heart palpitations					
Blood pressure changes (significantly lower or higher)					
Frequent urination					
Sexual dysfunction					
Feeling worse or different when the medication wears off (rebound)					
Other:					

Items to discuss at the next medical appointment:

_____

_____

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