ADVANCED PEDIATRIC ASSOCIATES
Hand in Hand for Healthy Kids

Date _____

Patient Name _____

Date of Birth _____

Phone Number _____

Dear Patient:

Our records indicate you are due for an ADHD medication evaluation visit. A new evaluation is required before a prescription can be refilled. It is the standard of care and our policy to see you every three (3) months to monitor your progress.

Enclosed please find questionnaires for you to complete. Please return the questionnaires to us by fax, email, or drop them off at a clinical office.

- Fax: 720-974-7189
- Email: apa.ref@advanced-pediatrics.com
- Clinical office locations:
  - 5657 S. Himalaya St., #100, Centennial, CO 80015
  - 1300 S. Potomac St., #156, Aurora, CO 80012
  - 9397 Crown Crest Blvd., #330, Alpine Building, Parker, CO 80138

After the forms have been received and reviewed by the provider, we will contact you to schedule an appointment for a medication evaluation.

Additional charges will be added to the next office visit for the provider's time to score and evaluate the questionnaires.

Please contact us at (720) 974-7188 if you have questions.

Sincerely,

ADHD Coordinator

Enclosures

Aurora Office
1300 S. Potomac Street, Suite 156 | Aurora, CO 80012

Centennial Office
5657 S. Himalaya Street, Suite 100 | Centennial, CO 80015

Parker Office
9397 Crown Crest Boulevard, Suite 330 | Parker, CO 80138

Administrative Office
3300 S. Parker Road, Suite 404 | Aurora, CO 80014

Phone | 303-699-6200 Fax | 303-766-6903

ADVANCED PEDIATRIC ASSOCIATES
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ADHD ADULT (17+) FOLLOW-UP QUESTIONNAIRE 1/2

Patient Name: _____ DOB: _____ Age: _____Today's Date: _____

Current ADHD or mental health medication(s):

Medication	Dosage	Time	Circle One
			AM / PM
			AM / PM
			AM / PM

Consider the following as you answer the questions below:

Physical	Emotional	Everyday Activities	Family/Home Life	Time of Day
Appetite Sleep patterns General well-being Energy level Hygiene	Interactions with family Interactions with friends	Works independently Focuses on an activity Completes tasks Participates in group	Stress level Energy level Tension levels at home Confidence in child's future	Morning During school/work After school/work Evening Bedtime

1. What has improved since your last visit?

   _____

   _____

2. Is anything worse since your last visit?

   _____

   _____

3. What strengths are you exhibiting at this time?

   _____

   _____

4. What could be improved?

   _____

   _____

ADVANCED PEDIATRIC ASSOCIATES
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ADHD ADULT (17+) FOLLOW-UP QUESTIONNAIRE 2/2

Please circle the number next to each item that best describes your behavior during the last 6 months.

Items:	Never or Rarely	Sometimes	Often	Very Often
1. Fail to give close attention to details or make careless mistakes in my work	0	1	2	3
2. Have difficulty sustaining my attention in tasks or fun activities	0	1	2	3
3. Don't listen when spoken to directly	0	1	2	3
4. Don't follow through on instructions and fail to finish work	0	1	2	3
5. Have difficulty organizing tasks and activities	0	1	2	3
6. Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort	0	1	2	3
7. Lose things necessary for tasks or activities	0	1	2	3
8. Am easily distracted	0	1	2	3
9. Am forgetful in daily activities	0	1	2	3
10. Fidget with hands or feet or squirm in seat	0	1	2	3
11. Leave my seat in situations in which seating is expected	0	1	2	3
12. Feel restless	0	1	2	3
13. Have difficulty engaging in leisure activities or doing fun things quietly	0	1	2	3
14. Feel "on the go" or "driven by a motor"	0	1	2	3
15. Talk excessively	0	1	2	3
16. Blurt out answers before questions have been completed	0	1	2	3
17. Have difficulty awaiting turn	0	1	2	3
18. Interrupt or intrude on others	0	1	2	3

To what extent do the problems you may have circled interfere with your ability to function in each of these areas?

Areas:	Never or Rarely	Sometimes	Often	Very Often
In my home life and daily responsibilities	0	1	2	3
In my school and educational activities	0	1	2	3
In my work or occupation	0	1	2	3
In my social interactions with others	0	1	2	3
In other activities (e.g. driving, recreational activities)	0	1	2	3

Over the last two weeks, how often have you been bothered by the following problems?

PHQ-4	Not at all	Several Days	More than half the days	Nearly Every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

0	≥1