

Patient Name _____

Date _____

ADHD Reassessment

Questionnaire for Adults With ADHD

The following questionnaire is intended to assist in reassessing the treatment plan for your adult patient with ADHD, in conjunction with a full clinical evaluation.

- When are your symptoms most bothersome? _____ AM/PM

- Are you able to organize and focus at work?
 YES NO

- Are you able to organize and focus at home?
 YES NO

- What time do you take your medication in the morning? _____ AM

- How often do you take your current medication? _____ x per day

- Do you feel that your ADHD symptoms are well controlled with your current ADHD treatment plan?
 YES NO

- Do you feel that your current ADHD medication is well tolerated?
 YES NO

Notes _____

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