GARDEN PSYCH

2088 US HWY 130, SUITE 105, MONMOUTH JUNCTION, NJ 08852

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Child’s Initials:\_\_\_\_\_\_\_\_\_ Rater Initials:\_\_\_\_\_\_\_\_\_\_\_ Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form completed by: Mother Father Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSTRUCTIONS: Check the column that best describes your child at the present time:

**INSTRUCTIONS:** Listed below are several possible negative effects (side effects) that medication may have on an ADHD child. Please read each item carefully and use the boxes to rate the severity of this child’s side effects during your contact with him or her today. When requested, or wherever you feel it would be useful for us to know, please describe the side effects that you observed or other unusual behavior in the “Comments” section below. **The same person should complete this scale each time it is completed.**

Use the following system to assess severity:

None: The symptom is assessed and is found absent.

Mild: The symptom is present but it is not sufficient to cause concern to the child, peers, or adults and would not affect a decision to recommend medication.

Moderate: The symptom causes impairment of functioning or social embarrassment to a degree that the benefits of medication must be considerable to justify the risks of continuing medication.

Severe: The symptom causes impairment of functioning or social embarrassment to a degree that the child should not continue to receive medication as part of treatment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NONE | MILD | MODERATE | SEVERE |
| 1. Motor Ties – repetitive movements: jerking or twitching (e.g., eye blinking-eye opening, facial or mouth twitching, shoulder or arm movements) – please describe below
 | 0 | 1 | 2 | 3 |
| 1. Buccal-lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting – please describe below
 | 0 | 1 | 2 | 3 |
| 1. Picking at skin or fingers, nail-biting, lip or cheek chewing – please describe below
 | 0 | 1 | 2 | 3 |
| 1. Worried/Anxious
 | 0 | 1 | 2 | 3 |
| 1. Dull, tired, listless
 | 0 | 1 | 2 | 3 |
| 1. Headaches
 | 0 | 1 | 2 | 3 |
| 1. Stomachache
 | 0 | 1 | 2 | 3 |
| 1. Crabby, Irritable
 | 0 | 1 | 2 | 3 |
| 1. Tearful, sad, depressed
 | 0 | 1 | 2 | 3 |
| 1. Socially withdrawn – decreased interaction with other
 | 0 | 1 | 2 | 3 |
| 1. Hallucinations (sees or hears things that aren’t there)
 | 0 | 1 | 2 | 3 |
| 1. Loss of appetite
 | 0 | 1 | 2 | 3 |
| 1. Trouble sleeping: (time went to bed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 | 0 | 1 | 2 | 3 |

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Person completing this form Relationship to Parent