Patient Name: ____________________

Date of birth: ____________________ MRN/File #: ____________

Clinician's Name: ________________ Date: ________________

CADDRA CLINICIAN ADHD BASELINE/FOLLOW-UP FORM

Other person present during Interview:

Clinician: Other therapist(s) involved:

Current medication(s):	Dose & schedule	Therapeutic Effects	Side Effects

Adherence to treatment: ☐ FULL (took medications as directed) ☐ 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:**	

Psychiatric Diagnosis:

☐ ADHD, Combined ☐ Learning Disorder ☐ Anxiety Disorder ☐ Conduct Disorder Personality
☐ ADHD, Inattentive ☐ Language Disorder ☐ Depression ☐ Disorder/Traits
☐ Oppositional Defiant ☐ Intellectual Disability ☐ Tic Disorder ☐ Other ____________

Medical Problems:

Stressors: ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Impairment Severity: ☐ Borderline ☐ Mild ☐ Moderate ☐ Marked ☐ Severe ☐ Extreme

Improvement ☐ Very much improved ☐ Much Improved ☐ Minimally Improved ☐ No change ☐ Minimally worse ☐ Much Worse ☐ Very much worse

Treatment Plan:

Medication Treatment Plan:

No Change	Increase	Decrease	Switch

Psychological/Other:

School/Work:

Follow-up plan:

Signature: ______________________________ Date ______________

Copy to be sent to: ______________________________