BrainDocs, PLLC Date: _____

OUTCOME PROGRESS REPORT

Changes in Address or Insurance: Yes ☐ No ☐ ; if yes, please see an office staff member.
Please see office staff member to add your preferred pharmacy.

Patient's Name: _____DOB_____

Height: _____*Inches* *Weight:* _____*Pounds*

Current Medications: _____

Guardian's Name: _____

Adverse Event Evaluation (please circle)

Appetite:	Good	Fair	Poor	Notes: _____
Sleep:	Good	Fair	Poor	Notes: _____
Attention:	Good	Fair	Poor	Notes: _____
Anxiety:	None	Low	High	Notes: _____
Mood:	Pleasant	Depressed	Anxious	Oppositional Other: _____
Taking Medication Regularly:	Yes	No		
Duration Effect of Medication (s):	12 hrs	10 hrs	8 hrs	6 hrs or less

Other Concerns: _____

_____

Review of Symptoms

Please circle the appropriate symptom:

ALLERGY:
Allergy Symptoms

CONSTITUTIONAL:
Fever, Fatigue,
Chills, Chronic Pain

CVS:
Chest Pain, Palpitation
Swelling of ankles

ENDOCRINOLOGY:
Temperature Intolerance
Hot Flashes, Excessive Thirst
Urinating Frequently

EYES:
Blurry Vision, Eye Pain
Visual Disturbance

GI:
Heartburn, Abdominal Pain
Vomiting, Nausea
Diarrhea, Blood in Stool
Rectal Bleeding

GENITOURINARY:
Painful urination, Blood in urine
Frequent Urination
Frequent urination at Night

HEENT:
Swollen Glands, Throat Pain
Ear Pain, Nasal Congestion

MUSCULOSKELETAL:
Neck Pain, Neck Stiffness
Joint Aches, Back Pain
Muscle aches

NEUROLOGY:
Headache, Dizziness
Lightheaded, Numbness
Tremors

RESPIRATORY:
Cough, Shortness of breath
Wheezing, Painful respiration

SKIN:
Rash, Acne

Office Use Only: ☐ Scanned

Please fill out front and back ➡

Children Rating Scale

A=most of the time B=Often C=occasionally D=Rarely E=Never

Patient Question	W/ Med	W/O Med
1. Does your child fail to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities?		
2. Does your child have trouble keeping attention on tasks or play activities?		
3. Does your child not seem to listen when spoken to directly?		
4. Does your child not follow instructions and fails to finish schoolwork, chores, or duties in the workforce?		
5. Does your child have trouble organizing activities?		
6. Does your child avoid, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time?		
7. Does your child lose things needed for tasks and activities?		
8. Is your child easily distracted?		
9. Is your child forgetful in daily activities?		
10. Does your child fidget with hands or feet or squirms in seat?		
11. Does your child get up from seat when remaining in seat is expected?		
12. Does your child run about or climbs when and where it is not appropriate?		
13. Does your child have trouble paying or enjoying leisure activities quietly?		
14. Is your child "on the go" or often acts as if "driven by a motor"?		
15. Does your child talk excessively?		
16. Does your child blurt out answers before questions have been finished?		
17. Does your child have trouble waiting one's turn?		
18. Does your child interrupt or intrude on other's		
19. Have symptoms been present for at least six months?		
20. Which of the following locations are these symptoms present as well? (Home, Work, School)	Home School Work	