

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:

<p>ALLERGY: Allergy Symptoms</p> <p>CONSTITUTIONAL: Fever, Fatigue, Chills, Chronic Pain</p> <p>CVS: Chest Pain, Palpitation Swelling of ankles</p> <p>ENDOCRINOLOGY: Temperature Intolerance Hot Flashes, Excessive Thirst Urinating Frequently</p>	<p>EYES: Blurry Vision, Eye Pain Visual Disturbance</p> <p>GI: Heartburn, Abdominal Pain Vomiting, Nausea Diarrhea, Blood in Stool Rectal Bleeding</p> <p>GENITOURINARY: Painful urination, Blood in urine Frequent Urination Frequent urination at Night</p> <p>HEENT: Swollen Glands, Throat Pain Ear Pain, Nasal Congestion</p>	<p>MUSCULOSKELETAL: Neck Pain, Neck Stiffness Joint Aches, Back Pain Muscle aches</p> <p>NEUROLOGY: Headache, Dizziness Lightheaded, Numbness Tremors</p> <p>RESPIRATORY: Cough, Shortness of breath Wheezing, Painful respiration</p> <p>SKIN: Rash, Acne</p>
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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	