Name: _____ Date: _____

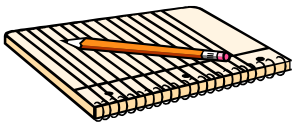
Monitoring Sheet
ADHD

SYMPTOMS

For each symptom, circle the number describing how much of a problem it was this week.
1=Not a Problem 3=Somewhat a Problem 5=Severe Problem

1 2 3 4 5
Trouble paying attention

1 2 3 4 5
Hard to sit still
or stay in seat



1 2 3 4 5
Trouble finishing school work

1 2 3 4 5
Hard to not blurt things
out or interrupt

1 2 3 4 5
Trouble finding or keeping
track of things

1 2 3 4 5
Trouble finishing chores
or tasks at home

1 2 3 4 5
Got in trouble for
talking too much

1 2 3 4 5
Got in arguments
or fights with others

1 2 3 4 5
Got in trouble for not
listening when spoken to

★★ Good Job ★★

Things I (my child) did well this week: _____

_____

_____

_____

ADHD

MEDICATIONS

These are the medications to take:

Name	Take When?			How Much
_____	Morning	During School	After School	_____
_____	Morning	During School	After School	_____
_____	Morning	During School	After School	_____
_____	Morning	During School	After School	_____
_____	Morning	During School	After School	_____

SIDE EFFECTS

For each side effect, circle the number that describes how much of a problem it was this week.
1=Not a Problem 3= Somewhat a Problem 5=Severe Problem

1 2 3 4 5
Trouble falling asleep

1 2 3 4 5
Too Sleepy

1 2 3 4 5
Not feeling hungry

1 2 3 4 5
Trouble with eyes

1 2 3 4 5
Feeling thirsty a lot

1 2 3 4 5
Feeling grouchy or irritable

1 2 3 4 5
Upset stomach

1 2 3 4 5
Feeling restless or fidgety

Other: _____