Follow-up Consultation *(page 1 of 2)*

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Doctor's Name: _____ MRN (office use only): _____

1. **Conditions being followed-up:** (check all that apply)
   - ☐ ADHD
   - ☐ Developmental disorders
   - ☐ Depression
   - ☐ Mood regulation
   - ☐ Anxiety / PTSD
   - ☐ Other: _____
   - ☐ Chronic medical conditions: _____
   - ☐ Don't know / don't remember

   Did your provider explain these diagnoses and reviewed treatment options and preferences with you? ☐ Yes ☐ No ☐ Don't remember

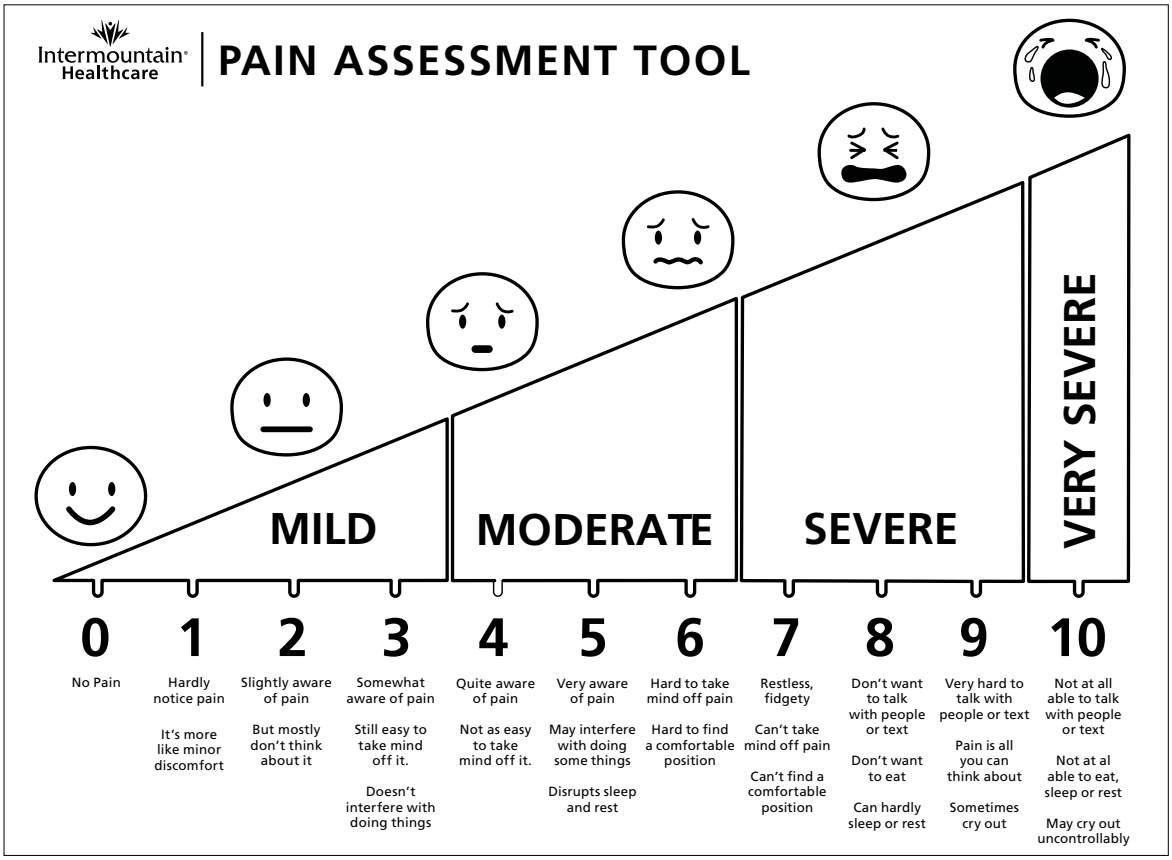
2. **Chronic pain assessment follow-up**

   Yes ☐ **No** ☐

   Does your child have pain every day?

   If so, please ask your child to choose the face that best describes the average daily level of pain.

   _____
   Average pain level (0–10)



3. **Sleep assessment follow-up**

   Yes **No**

   ☐ ☐ Does your child have problems sleeping? If yes, answer the following:

   On average, how many hours does your child sleep when he or she is having problems? _____

   How bad has your child's sleep problem been since your last visit?

   ☐ 0 not present ☐ 1 ☐ 2 a little bad ☐ 3 ☐ 4 pretty bad ☐ 5 ☐ 6 ☐ 7 very bad ☐ 8 ☐ 9 ☐ 10 couldn't be worse

4. **School absence**

   _____ Since your last visit, how many days of school has your child missed because of his or her mental health problems?

   # days missed

Follow-up Consultation *(page 2 of 2)*

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5. **Overall impairment.** Check the number by the statement that best describes how much you think your child is impaired (negatively affected or hurt) by his problems right now. (Compare your child to typical children of the same age and gender, in the same situations.)

- ☐ **1 No impairment.** Symptoms are *not present any more than expected* and *do not impair* normal functioning at home or school.
- ☐ **2 Slight impairment.** Symptoms are present *a little more frequently or intensely than expected* and *only rarely impair* normal functioning at home or school.
- ☐ **3 Mild impairment.** Symptoms are present *somewhat more frequently or intensely than expected* and *sometimes impair* normal functioning at home or school.
- ☐ **4 Moderate impairment.** Symptoms are present *a lot more frequently or intensely than expected* and *usually impair* normal functioning at home or school.
- ☐ **5 Severe impairment.** Symptoms are present *a great deal more frequently or intensely than expected* and *most of the time impair* normal functioning at home or school.
- ☐ **6 Very severe impairment.** Symptoms are present *so much more frequently or intensely than expected that they almost always impair* normal functioning at home or school.
- ☐ **7 Maximal (profound) impairment.** Symptoms are present *so frequently or intensely that they produce significant and pervasive impairment,* which creates a crisis requiring immediate action to prevent serious deterioration to avoid or prevent harm.

6. **Rating of improvement.** Since your last visit, has your child shown any improvement in functioning at school or at home?

	No improvement	Mild improvement	Moderate improvement	Significant improvement
1. School	☐	☐	☐	☐
2. Home	☐	☐	☐	☐

7. **Self-management progress.** Please check the aspects of self-management your child has successfully focused on since your last visit:

☐ Taking medications ☐ Counseling ☐ Improving nutrition ☐ Exercising ☐ Spirituality

☐ Hobbies and fun activities ☐ Support from family/friends ☐ Other: _____

I feel confident in my child's ability to effectively take care of his or her own health needs as appropriate for his or her age.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

not at all confident — somewhat confident — confident — very confident — extremely confident

8. **Medication follow-up**

Is your child taking any new medications since your last visit?

Name and dose of medication	When started?	Has well does it work?	What side effects?

Has your child had any side effects from any of his or her medications, such as stomach or digestive problems, headache, sleeping problems, tiredness, or anything else? List below.

Name and dose of medication	What side effects?

For use by healthcare provider:

BP: _____ /_____ HR: _____ EKG: _____

Labs: _____ Other: _____

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