HAYWOOD PEDIATRIC & ADOLESCENT MEDICINE GROUP, P.A.

ADHD Side Effect Checklist

Child's Name: _____ Date Completed ___ ___ - ___ ___ - ___ ___

Your Name: _____ Relationship to Child: _____

Read each item below carefully, and decide how much you think your child has been bothered by this problem IN THE PAST MONTH. Circle your single best answer. Do not mark between choices. Please be sure to answer every item.

		NONE	MILD	MODERATE	SEVERE
1	Appetite loss …….……..	1	2	3	4
2	Trouble sleeping……..	1	2	3	4
3	Sluggish, Tired, Listless……..	1	2	3	4
4	Crabby, Irritable……	1	2	3	4
5	Tearful, Sad, Depressed……..	1	2	3	4
6	Worried/Anxious……..	1	2	3	4
7	Motor Tics - repetitive movements: jerking or twitching (eg, eye blinking- eye opening, facial or mouth twitching)……..……..	1	2	3	4
8	Picking at skin or fingers, nail biting, lip or cheek chewing……	1	2	3	4
9	Stomachaches…….	1	2	3	4
10	Headaches……	1	2	3	4