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Non-stimulant trial

Child's name: _____Grade: _____ Year: _____

Person completing this form: _____Relation to child: _____

When were your observations usually made? (circle): mornings/ afternoons/ evenings/ weekdays/ weekends

Dear Parents, Teachers, and Student:
Thank you very much for your help. It is so important to conduct this medication trial in a careful and controlled fashion. Please complete the table below. Record observations once each week. Your comments in narrative form are also very helpful. On the back, please record the date and describe the following: If there were side effects, at what time did you usually notice this? Do medicine benefits seem to "kick-in" too late or "wear off" too early? General comments about side effects. General comments about benefits. Please call me if you have any questions or concerns. Thank you.

How often did you notice the following? 0=not at all, 1=just a little, 2=often, 3=very often

DOSE										
TARGET SYMPTOMS DATE										
Restless, squirmy, fidgety, "on-the-go"										
Demands must be met immediately										
Distractibility/ attention problem										
Problems with peer relations										
Misses important details										
Impulsive, blurts out										
Fails to initiate, sustain, finish tasks										
Problems controlling behavior										
Easily frustrated										
Difficulty learning										
Disorganization/ time mismanagement										
Tics										
POSSIBLE SIDE EFFECTS										
Poor appetite										
Nausea/ stomach aches										
Irritability/ sadness										
Social withdrawal										
Headaches										
Dizziness										
Drowsiness										
Anxiety/ nightmares										
Stares off/ daydreams										