

YOUR OR YOUR CHILD'S NAME:

DATE:

CURRENT ADHD MANAGEMENT PLAN:

**1 Do you/does your child struggle to make it to work/school on time?**

**1**  Never

**2**  Sometimes

**3**  Most of the time

**2 Do you find your/your child's ADHD gets worse in the evening?**

**1**  Not at all

**2**  A little worse

**3**  A lot worse

**3 Do you/does your child have difficulty with relationships at home and/or with friends?**

**1**  Not at all

**2**  Some difficulty

**3**  A lot of difficulty

**4 Do you/does your child struggle with evening tasks and chores  
(e.g., homework, paying bills, doing dishes, laundry, getting ready for bed)?**

**1**  Not at all

**2**  Some struggling

**3**  A lot of struggling

**5 Do you/does your child struggle with self-control/self-regulation in the evenings  
(e.g., easily frustrated, losing temper, online shopping, gambling, substance use)?**

**1**  Not at all

**2**  Sometimes

**3**  Most evenings

If most answers were **2** and **3**, it might be time to take a closer look at how your or your child's ADHD might be better managed. Talk to your doctor about your treatment options.

**Better** can be **possible**