Pediatric ADHD: Primary Care Quick Guide

This guide is for primary care physicians and other frontline diagnostic and treatment professionals.

Confirm the pattern

For children ≤16:

- ≥6 symptoms of inattention and/or hyperactivity-impulsivity
- Present for ≥6 months
- Several symptoms before age 12
- Present in ≥2 settings
- Developmentally inappropriate and functionally impairing
- Not better explained by another condition

Common ADHD Mimics

Consider	Key Clues
Sleep	Insufficient sleep, delayed onset, snoring, apnea, restless sleep
Anxiety	Worry, perfectionism, somatic symptoms, avoidance
Learning disorder	Difficulty in reading, writing or math; attention better with accessibility
Depression	Anhedonia, withdrawal, sadness, irritability, sleep/appetite change
Trauma/stress	Abrupt onset, vigilance, dissociation, avoidance, linked to reminders
Autism/developmental delay	Social-communication delays, restricted interests, repetitive behaviour
Medical/substance factors	Hearing or vision problems, medication effects, cannabis, etc.

Clinical Pearl: TRACK the Problem

T - Timing: When did it begin? Longstanding or recent problem?
R - Range: Where does it occur? Across at least two settings or only one?
A - Activities: Which tasks or demands reliably elicit symptoms?
C - Cognition: Where does the child's mind go? Boredom, worry, confusion, fatigue, trauma?
K - Key impairment: What is functionally impaired? Are the symptoms the likely source of impairment?

Effect Sizes for What Works*

Stimulant Medication	Other Treatments
Amphetamine formulations: 1.16	Nonstimulants: 0.52
Stimulants overall: 0.88	Youth psychosocial treatment: 0.35
Methylphenidate: 0.68	Parent intervention: 0.31

Remember: Medication improves core symptoms but does not remediate learning disorders, teach organizational skills, treat anxiety, or repair family conflict.

Match the Intervention to the Target

Symptom	Best Intervention
Core ADHD Symptoms	Medication
Oppositional behaviour/routines	Parent Management Training (PMT); Child-Parent Interaction (CPIT)
Organization	Explicit organizational skills training
Anxiety/depression	Targeted CBT (and possibly medication)
Academic delay	Evidence-based academic intervention
Classroom behaviour	Contingency management (reinforcement); home-school coordination

Primary Care Physicians Can Usually...

- Diagnose straightforward ADHD
- Obtain parent and teacher information
- Screen common mimics and comorbidities
- Initiate and titrate medication
- Monitor growth, appetite, sleep, blood pressure and heart rate
- Track functional outcomes
- Recommend parent and school interventions

Routine laboratory testing, EEG, neuroimaging or ECG is not required in a typical presentation.

Refer to Psychology When...

- The diagnosis or differential remains unclear
- Reports conflict or symptoms are setting-specific
- Anxiety, trauma, autism or mood symptoms complicate the presentation
- A learning disorder is suspected
- Impairment persists despite appropriate treatment
- Parent training, CBT, organizational intervention or family work is needed
- Detailed educational planning or documentation is required

* Peterson, B. S., Trampush, J., Maglione, M., Bolshakova, M., Rozelle, M., Miles, J., Pakdaman, S., Brown, M., Yagyu, S., Motala, A., & Hempel, S. (2024). Treatments for ADHD in children and adolescents: A systematic review. *Pediatrics, 153*(4), e2024065787. https://doi.org/10.1542/peds.2024-065787

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