mobile pediatric
CLINIC

Help Us Get to Know Your Child

Parents, please have your child complete this questionnaire or ask questions and quote answers directly if child can't complete independently.

What do you do well?

What do you enjoy doing most?

What is your favorite thing about school?

What is your least favorite thing about school?

Is it hard for you to sit still?

Is it hard to wait your turn? If you have to wait in line, or if you want to give an answer, is that hard for you?

Does your teacher think you talk too much?

Is it hard to pay attention to the teacher?

Is it hard to keep up with things like pencils, books, jackets, or sports equipment?

Is homework hard to finish?

Do you or your parents ever cry or yell over doing homework?

Do you have a good friend at school?

Do you worry a lot?

Are you sad a lot?

mobile pediatric CLINIC

Name of Person Completing These Forms: _____ Relationship to Patient: _____

REVIEW OF SYSTEMS:

Constitutional

☐ Yes ☐ No Decreased Appetite
☐ Yes ☐ No Decreased Appetite at Lunch
☐ Yes ☐ No Excessively Sleepy
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Problems Falling/Staying Asleep
☐ Yes ☐ No Tired
☐ Yes ☐ No Weight Gain
☐ Yes ☐ No Weight Loss

Eyes

☐ Yes ☐ No Frequent Blinking/Squinting
☐ Yes ☐ No Itching/Rubbing Eyes
☐ Yes ☐ No Vision Problems

Ears/Nose/Throat

☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Large Tonsils
☐ Yes ☐ No Snoring

Respiratory

☐ Yes ☐ No Cough at Night/Wakes Patient
☐ Yes ☐ No Frequent Cough
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Tightness in Chest
☐ Yes ☐ No Trouble Breathing

Heart/Vascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Heart Racing/Fast Heart Rate
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Palpitations

Gastrointestinal

☐ Yes ☐ No Blood in Stool
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Frequent Abdominal Pain
☐ Yes ☐ No GERD/Reflux/Frequent Heartburn
☐ Yes ☐ No Stool Leakage/Accidents
☐ Yes ☐ No Vomiting

Musculoskeletal

☐ Yes ☐ No Clumsy
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Limp or Gait Disturbance

Psychiatric

☐ Yes ☐ No Aggression
☐ Yes ☐ No Anxious, Worries
☐ Yes ☐ No Apathetic/Lazy
☐ Yes ☐ No Attempts at Self Harm, Suicide
☐ Yes ☐ No Cutting Behavior
☐ Yes ☐ No Depressed, Sad
☐ Yes ☐ No Flat Affect/Zombie-like

Psychiatric

☐ Yes ☐ No Frequent Anger
☐ Yes ☐ No Hypersexual Behavior
☐ Yes ☐ No Irritable, Touchy
☐ Yes ☐ No Low Self Esteem
☐ Yes ☐ No Mood Issues Related to Menstruation
☐ Yes ☐ No Not Sleeping for over 24 Hours
☐ Yes ☐ No Obsessive Compulsive Behaviors
☐ Yes ☐ No Overly Confident or Grandiose
☐ Yes ☐ No Paranoid, hears/sees things others don't
☐ Yes ☐ No Racing Thoughts
☐ Yes ☐ No Rigid, Inflexible
☐ Yes ☐ No Sensory Issues- Hates Tags, Loud Noises, Problems with Food Textures
☐ Yes ☐ No Special Abilities
☐ Yes ☐ No Thoughts of Self Harm, Suicide

Skin/Hair/Nails

☐ Yes ☐ No Acne
☐ Yes ☐ No Eczema
☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Sores or Rashes
☐ Yes ☐ No Twirls or Pull Hair/Picks at Skin, Nails

Neurological

☐ Yes ☐ No Blank Staring Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Motor Tics – Blinking, Jerking
☐ Yes ☐ No Seizures
☐ Yes ☐ No Tremor
☐ Yes ☐ No Verbal Tics – Sniffing, Throat Clearing, Vocalizing
☐ Yes ☐ No Weakness

Endocrine

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Frequent Urination/Drinks Excessive Fluids
☐ Yes ☐ No Problems with Growth/Short Stature
☐ Yes ☐ No Thyroid Problems

Heme/Lymph

☐ Yes ☐ No Anemia
☐ Yes ☐ No Easily Bruised

Allergic/Immunologic

☐ Yes ☐ No Allergies
☐ Yes ☐ No Asthma
☐ Yes ☐ No Food Allergy

Genito/Urinary

☐ Yes ☐ No Bed Wetting
☐ Yes ☐ No Frequent Urinating
☐ Yes ☐ No Irregular, Heavy Period
☐ Yes ☐ No Significant Menstrual Pain
☐ Yes ☐ No Urine Accident/Incontinence

mobile pediatric
CLINIC

ALLERGIES:

Does the child have any drug allergies? ☐ Yes ☐ No
If so, please name and describe the reaction: _____
The reaction is ☐ Mild ☐ Moderate ☐ Severe

Does the child have any food allergies? ☐ Yes ☐ No
If so, please name and describe the reaction: _____
The reaction is ☐ Mild ☐ Moderate ☐ Severe

CURRENT ADHD MEDICATIONS: ☐ **None**

Medication Name	***Dosage***	***Frequency***	***Duration***
	_____ mg _____# tabs Time taken: _____ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			
	_____ mg _____# tabs Time taken: _____ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: ☐ **None**

Medication Name	***Dosage***	***Frequency***	***Duration***
	_____ mg _____# tabs Time taken: _____ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			

OTHER CURRENT MEDICATIONS: _____

PAST ADHD MEDICATIONS IN LAST 2 YEARS:

Medication Name: _____ Dose: _____mg _____ mg _____ mg
Side Effects (if any): _____
How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

Medication Name: _____ Dose: _____mg _____ mg _____ mg
Side Effects (if any): _____
How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

Medication Name: _____ Dose: _____mg _____ mg _____ mg
Side Effects (if any): _____
How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

mobile pediatric
CLINIC

- What are your main concerns regarding the patient?
  (i.e. inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behaviors, etc.)
  _____
  _____

FAMILY HISTORY:

Please indicate with a √ if any of your immediate family members have experienced any of the following conditions.

Initial if none: _____

	Mother	Father	Sibling	Sibling 2	Grandparent	Aunt/Uncle
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Mood Disorder						
Bipolar Disorder						
Depression						
Schizophrenia/Nervous Breakdown						
Tics/Tourette's						
Headache/Migraines						
Autism/Asperger's						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age of 40						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						
Asthma						

mobile pediatric CLINIC

MEDICAL HISTORY:

***Newborn History*: (For the patient)**

- Were there any pregnancy complications? ☐ Yes ☐ No
  ☐ Preterm Labor ☐ Meds During Pregnancy ☐ Drug/Alcohol use During Pregnancy
  ☐ Other Exposure During Pregnancy ☐ Infection During Pregnancy ☐ Hypertension ☐ Diabetes
- Length of pregnancy? ☐ Term ☐ Premature ☐ Overdue ☐ Induced # Weeks: _____
- Type of delivery: ☐ C-Section ☐ Vaginal ☐ Vacuum Assisted ☐ Forceps Assisted ☐ Meconium
- Were there any delivery complications? ☐ Yes ☐ No
  ☐ Difficult Delivery ☐ Nuchal Cord ☐ Hemorrhage
- Were there any problems after delivery? ☐ Yes ☐ No
  ☐ Jaundice ☐ Breathing Problems ☐ Bleeding in Brain ☐ Bowel Problems ☐ Sepsis/Infection

Developmental History:

Please mark when the child achieved the following milestones (E = early, A = average, or L = late) when compared to others his/her age (explain if late):

- _____ Speech/Language (single words, sentences)
- _____Fine Motor Skills (stacking blocks, thumb-finger grasp, drawing circle)
- _____Gross Motor Skills (rolling over, standing, walking)
- _____Toilet Training

Has there been any regression? _____

Sleep History:

- Does the child have a history of sleeping problems? (since infant/toddler years) ☐ Yes ☐ No
  ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐ Sleep Walking ☐ Talking in Sleep
  ☐ Frequent Nightmares ☐ Frequent Night Terrors ☐ Vivid Dreams
- Has the child gone longer than 24 hours without sleep? ☐ Yes ☐ No
  If yes, did the child seem tired the next day? ☐ Yes ☐ No
  How often has this occurred? _____
  What is the maximum number of days the child has gone without sleep? _____
- Does the child sleep after school? ☐ No ☐ Yes, Daily ☐ Yes, Occasionally How long? _____
- Does the child seem tired during the day? ☐ Yes ☐ No
- Does the child fall asleep during the day? ☐ Yes ☐ No

Behavioral/Mental Health History:

- Has the child ever been formally diagnosed with ADHD? ☐ Yes ☐ No
  If yes, when was he/she diagnosed and by whom? _____
  - Do you have documentation of the diagnosis? ☐ Yes ☐ No
  - Is child currently under a provider's care for ADHD? ☐ Yes ☐ No
  - If yes, name of provider: _____

mobile pediatric CLINIC

Why are you changing ADHD providers? _____

- Has the child ever received IQ or Academic testing? ☐ Yes ☐ No
  - Diagnosed with ☐ Dyslexia ☐ Learning Disability ☐Other Diagnosis _____
- Has the child ever participated in counseling, behavioral modification, or therapy? ☐ Yes ☐ No
  If so, please explain:

  _____
- Has the child every experienced any of the following conditions or symptoms?
  - Depression (sad, irritable, hopeless, tearful, lack of interest, social withdrawal) ☐ Yes ☐ No
  - Anxiety (worry, fearful, obsessive thoughts, frequent headaches/stomach aches) ☐ Yes ☐ No
  - Behavioral problems (defiance, argumentative, refusals, anger, aggression, school suspensions or detentions) ☐ Yes ☐ No
  - Verbal tics (throat clearing, repeating words) ☐ Yes ☐ No
  - Motor tics (blinking, face muscle twitching) ☐ Yes ☐ No

General Medical History:

- Has the child been hospitalized? ☐ Yes ☐ No
  If yes, please explain: _____
- Has the child ever had a concussion or head injury? ☐ Yes ☐ No If yes, date: _____
- How is the child's vision? ☐ Normal ☐ Vision impairment ☐ Wear corrective lenses or contacts
- How is the child's hearing? ☐ Normal ☐ Some hearing impairment ☐ Uses hearing aid

Please check if the child has ever experienced any of the following symptoms or conditions: ☐ None

☐	Heart Murmur	☐	Cardiac Abnormality	☐	Asthma/Allergies
☐	Enuresis (daytime accidents)	☐	Bedwetting	☐	Encopresis (soiling w/stool)
☐	Constipation/Diarrhea	☐	Thyroid Problems	☐	Frequent Ear Infections
☐	Seizures	☐	Reflux	☐	Headaches/Migraines
☐	Diabetes	Other:			

SURGICAL HISTORY:

- Tubes ☐ Yes ☐ No # Sets _____ 1st set at what age? _____
- Adenoidectomy ☐ Yes ☐ No
- Tonsillectomy ☐ Yes ☐ No
- Appendectomy ☐ Yes ☐ No
- Other surgery: _____

SOCIAL HISTORY:

- Is the patient your biological child? ☐ Yes ☐ No If adopted, at what age? _____
- Has the child ever been the victim of abuse or neglect? ☐ Yes ☐ No

mobile pediatric CLINIC

- Parent Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married

- The patient lives with: ☐ Parents ☐ Mom ☐ Dad ☐ Mom/Step-dad ☐ Dad/Step-mom
  ☐ Grandparent ☐ Other relative ☐ Non-relative
  If child does not live with both parents, how often does the child see the non-custodial parent?
  ☐ Frequently/equally ☐ At least weekly ☐ Rarely ☐ No relationship
  ☐ Every other week ☐ Monthly ☐ Less than monthly
- Does the child have a consistent nighttime routine? ☐ Yes ☐ No
  ☐ Has a TV in the bedroom ☐ Watches TV/uses electronics before bedtime
  Usual bed time: _____ Usual wake time: _____
- Does the child have any dietary restrictions? ☐ Yes, Explain. _____
  ☐ Regular diet ☐ Vegetarian ☐ Other _____
- How would you rate the child's physical activity level?
  ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/ "couch potato"
- How many caffeinated beverages does the child drink each day?
  ☐ None ☐ <1 ☐ 1-3 per day ☐ 3+ per day
- Where does the child attend school? _____ Grade: _____
- How is the child's academic performance? ☐ Good ☐ Fair ☐ Poor ☐ Failing/Danger of failing
  ☐ Problems with reading ☐ Problems with writing ☐ Problems with math
  ☐ No Problem ☐ Somewhat of a problem ☐ Moderate Problem ☐ Significant Problem
- How is the child's school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns ☐ Other
  ☐ No problem ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem
- Does the child receive any school based accommodations? ☐ Yes ☐ No ☐ Needed, but reluctant to use

  ☐ Resource classroom
  ☐ IEP
  ☐ 504 Plan accommodation
  ☐ Extended time on testing
  ☐ Testing in a quiet environment
  ☐ Individual testing
  ☐ Reduced work volume
  ☐ Response to intervention
  ☐ Informal accommodations
  ☐ Other: _____

- Has the child failed a grade or been held back? ☐ Yes ☐ No If yes, which grade? _____
- Does the child have any hobbies or activities they enjoy?

  ☐ Sports/athletics
  ☐ Music/Band
  ☐ Drama
  ☐ Martial arts
  ☐ Art/Creative writing
  ☐ Electronic/Media time is a problem
  ☐ Hunting/Fishing/Outdoors
  ☐ Video Games _____ Hours per day
  ☐ Social Media _____ Hours per day
  ☐ TV/Other Media _____ Hours per day
  ☐ School Clubs/Social Clubs
  _____ Hours per day total electronic time

- Describe the child's after school routine:
  ☐ Tutoring/Educational Intervention
  ☐ Unstructured
  ☐ Volunteer
  ☐ After school care
  ☐ Car Rider
  ☐ Rides Bus

☐ Homework is done after school ☐ Homework is delayed until evening

- How is the child's behavior at home?
  - ☐ Good behavior
  - ☐ Problems with time management
  - ☐ Problems with task completion
  - ☐ Meltdowns
  - ☐ Homework problems
  - ☐ Oppositional behavior
  - ☐ Disrespectful behavior

  ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the child's relationships with family members?
  - ☐ No unusual stress
  - ☐ Parent/child conflict
  - ☐ Conflict with non-custodial parent
  - ☐ Conflict with other family members
  - ☐ More than usual conflict with siblings
  - ☐ Step-parent/child conflict
  - ☐ Conflict with custodial parent/guardian

  ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- How are the child's relationships with peers?
  - ☐ Healthy, identifies friends
  - ☐ Doesn't identify friends
  - ☐ Significant conflict
  - ☐ Limited friendships
  - ☐ Some conflicts
  - ☐ Problems making/keeping friends

  ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any bullying issues?
  - ☐ No problems
  - ☐ Child bullies others
  - ☐ Bullying is being addressed
  - ☐ Child is teased/picked on
  - ☐ Bullying is ongoing

  ☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

- Have there been any major stressors for the patient during the past year?
  - ☐ Family conflict
  - ☐ Peer relationships
  - ☐ School performance
  - ☐ Sibling relationships
  - ☐ Financial stressors
  - ☐ Substance abuse in home
  - ☐ Absent parent
  - ☐ Serious illness in the family
  - ☐ Death in the family
  - ☐ Natural disaster
  - ☐ Loss of housing
  - ☐ Other: _____

mobile pediatric
CLINIC

CONTROLLED SUBSTANCE AGREEMENT

I, _____, a patient/parent of _____ Mobile Pediatric Clinic, have been informed that individuals who are prescribed certain controlled substances including stimulants can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction.

Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my ADHD/ADD.

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

2. I understand prescriptions for controlled substances cannot be called in, faxed in, or mailed in to the pharmacy. Prescriptions must be hand delivered to the pharmacy.

3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform Mobile Pediatric Clinic.

4. I will inform Mobile Pediatric Clinic of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

5. I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

6. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

7. I will not allow anyone else to have, use sell, or otherwise have access to these medications. <u>The sharing of medications with anyone is absolutely forbidden and is against the law</u>.

8. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

9. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

10. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

11. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.

12. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by my physician.

13. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.

14. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by Mobile Pediatric Clinic**.** Failure to comply may result in immediate discharge from the practice.

15. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

16. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, **a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered.** If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice.

17. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

18. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

19. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.

20. I understand that I may be asked to bring my medications in their original container to **Mobile Pediatric Clinic's** office while I am on controlled medication.

21. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by Mobile Pediatric Clinic.

22. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.

23. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.

I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

_____	_____
Patient Name	Patient Signature
_____	_____
Parent Signature	Physician Signature
_____	_____
Date	Date

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals