



Pediatric Associates of the Northwest, P.C.

Dear Parent,

You have expressed interest in having your child evaluated for behavioral concerns or possibly Attention Deficit Disorder.

It is critical that we understand completely your child's difficulties in all areas. It is important that we evaluate information from home as well as school.

We are asking that you complete the enclosed questionnaire as well as the enclosed rating scales. Some of the information will seem very redundant. This is necessary to ensure that we obtain accurate diagnostic information.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write, "Don't know," so that we can be sure the item was not simply overlooked.

Additionally, we would like the teacher to fill out some rating forms and questionnaires. These forms are enclosed. Please take them to the school and ask the teacher(s) to complete them. You may either pick them up and bring them to us when they are completed, or ask the school to mail them directly to us.

Before we can schedule an appointment for this evaluation, we need the following pieces of information at the clinic:

1. Parent questionnaire
2. Parent rating forms
3. Teacher questionnaire and rating forms
4. Samples of your child's school work
5. Copies of any previous educational/psychological evaluations
6. Copies of any previous pertinent medical records concerning this problem

Once the information is completed we will be happy to schedule an appointment with your child's physician.

Thank you for your efforts in completing this. If you have any questions, please do not hesitate to contact us.

Name _____ Chart # _____

Child and Family Information Form
Health, Behavior and Development History
School Aged Children

Child's Name		Date
Age	Birthdate	School Grade
Address		
City	State	Zip
Home phone #	Other phone #(s)	
Parents Name(s)		
Person completing this form		
School		
Teacher's Name		
School's Address	Phone #	

Upon completion this questionnaire will become part of your child's confidential medical record, not to be shared with any person without your written permission. The information you provide will be used to assess your child, identifying areas of difficulty and making it possible to develop a plan for helping him or her. Please answer as completely as you can, using the backs of the pages or attaching additional sheets if needed.

Present Family Information (Current Family Responsible for Child)

Father's Name	Age	Education
Mother's Name	Age	Education
Father's Occupation	Currently Employed?	Length of Employ.
Place of Employment		
Mother's Occupation	Currently Employed?	Length of Employ.
Place of Employment		
Is this child adopted?		
Does the child have any step-parents?		
Does the child have a legal guardian(s) other than the biological parents?		
Are the child's biological parents living in the same household with the child?		
Are the child's biological parents married? Separated? Divorced? Deceased?		

Please list all children in the family (living or deceased)

Name	Age	School Grade/Occupation

Are there any other people living in the child's household?

Name	Age	Relationship

What behaviors and/or difficulties does the child have that you are concerned about?

When did you first start having these concerns about the child?

State any factors that you believe may be causing or adding to the child's difficulties.

Please list your child's strengths—or describe what you admire about the child.

What do you see as your child's weaknesses?

Previous Evaluations and Treatments

Has the child had previous evaluations for these difficulties inside or outside of school?

If yes, where and when? _____

It would be helpful if you send a copy of the report(s) when you send in this form. Please attach copies of any available reports if you have them. If you do not have copies of previous reports, please sign the enclosed release of information form so that we may obtain them.

Health and Temperament

Has your child had or is your child having any of the following: Yes No Ages

	Yes	No	Ages
Chronic health problem(s)			
Hospitalizations			
Medications used over a long period of time in the past			
Unconsciousness or coma			
Serious head injury			
Seizures			
Repetitive movements or noises that he/she can't control			
Speech delays			
Other delays in development			
Ear problems			
Eye problems			
Allergies			
Anemia			
Thyroid problems			
Exposure to lead*			

*Such as living in a building built before 1960, exposure to chipped or peeling paint, exposure to another person who works with lead in batteries, bullets, figurines, etc.

If the answer to any of the questions above is yes, specify details below:

Has your child ever had any of the following temperament characteristics?

Yes No Ages

	Yes	No	Ages
Colic			
Feeding or eating problems			
Problem with growth (height and/or weight)			
Bedwetting (beyond 5 years old)			
Other problems with bladder control			
Soiling of undergarments with bowel movement			
Tantrums (more than other children of same age)			
Unwillingness to change daily routine(s)			
A time when he/she had a greatly decreased need for sleep			
A time when his/her thoughts seemed to be racing			

If yes, please explain below as necessary:

Has your child ever received any type of mental health treatment? Yes No

If yes, provide details below:

Approximate Date(s)	By Whom	Nature of Problem	Medication, if prescribed

Has your child ever been diagnosed by a professional as being hyperactive or as having an attention deficit disorder? _____

If yes, how old was your child when this diagnosis was made? _____ Who made the diagnosis? _____

Has your child received, or is the child currently receiving, medication for hyperactivity or attention deficit disorder? _____

If yes, provide details below:

Type of Medication	Dosage	# of Times Given Each Day	Age of Child When Medication Used

Does your child take any other medications on a regular basis? _____ If yes:

Type of Medication	Dosage	# of Times Given Each Day

Does your child take any herbal or natural supplements or medicines? _____

If yes, please list substance and how often it is used. _____

Pregnancy, Delivery and Newborn Periods

	Yes	No	Unsure
Where there any significant complications during the pregnancy?			
During the pregnancy did the mother:			
Have to take medications?			
Drink alcohol?			
Take any drugs?			

If the answer to any of the questions above was yes, please explain as necessary.

	Yes	No	Unsure
Were there any significant complications during the delivery?			
Was the delivery a Caesarian section?			
Was the baby:			
Premature?			
In the hospital more than 4 days?			
Born with any birth defects?			
Did the baby:			
Need oxygen?			
Have seizures?			
Have an infection?			

The duration of labor was _____ hours.

The baby's birth weight was _____ pounds.

If the answer to any of the questions above was yes, please explain as necessary.

Neurodevelopmental Skills

Below is a chart of skills. Please rate your child as he/she compares with other children of his/her own age. Place an X in the appropriate box.

Skill	Better	Average	Worse
Catching and throwing a ball			
Running			
Building things like models, Legos			
Drawing/art			
Writing			
Understanding spoken directions			
Speaking clearly			
Describing things			
Ability to remember things			

School History

In the chart below check off yes or no to answer each question and list the grade(s) during which the “yes” problems occurred.

Has your child had any of the following problems in school:	Yes	No	Grades
Speech or language problems			
Reading problems			
Writing problems			
Spelling problems			
Math problems			
Other problems (specify _____)			
Other problems (specify _____)			
Been in a Special Classroom			
Been in a Resource Classroom			

Has your child ever been diagnosed with a learning disability? _____

(If yes list the grade when diagnosis occurred) _____

At what age did your child begin school (of any type)? _____

Peer Relationships

Are there children in your neighborhood around the same age as the child? _____

Does your child seek friendships with peers? _____

Do peers seek out your child for friendships? _____

Does your child play with children primarily younger__ or older__ than his/her own age?

Briefly describe any problems your child may have with peers: _____

Has your child ever attended a child care facility, either center based or in a private home? _____

If yes, please give age(s) and briefly describe each setting (center or home, #of children). Also please summarize what the experience was like for your child.

Stressors

Please list any unusual and/or traumatic family event in the child's life which you feel may have impacted upon his/her development and current problems. Such stressors might include the birth or death of a sibling, any death in the family, divorce, illness in the family, frequent moves and/or school changes, etc.

Incident	Child's Age	Comments

Family History and Structure

Do any family members, including the child's biological parents, grandparents, siblings, aunts or uncles, have a history of:

	Yes	No	Comments
Hyperactivity in childhood			
Behavior problems			
School difficulties			
Learning problems			
Being kept back in school			
Neurological problem (seizures, tics, Tourette's Syndrome, other)			
Mental retardation, autism, or other developmental disorder			
Alcohol or drug abuse			
Sexual or physical abuse			
Mental or emotional problem such as anxiety, depression, bipolar disorder, schizophrenia, suicide, etc.			
Thyroid disease			

Any further comments or information: _____

What methods have been used to improve the child's behavior at home:

	Yes	No	Comments
Verbal reprimands			
Spanking			
Withdrawal of privileges			
"Grounding" from social activities			
Rewards			
Time Out			

Which method(s) have worked best? _____

Thank you for completing this form.

Reviewed by: _____ Date: _____

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

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American Academy
of Pediatrics



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NICHQ

National Initiative for Children's Healthcare Quality

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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: _____

