

## Vanderbilt Parent Assessment Follow-Up

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Each rating should be considered in the context of what is appropriate for the age of your child.

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

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 misunderstanding)	0	1	2	3		
5. Has difficulty organizing task and activities	0	1	2	3		
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental efforts	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	<input type="checkbox"/> <small>Coeff 26-36</small>	
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/her turn	0	1	2	3	<input type="checkbox"/> <small>Coeff 26-36</small>	
18. Interrupts or intrudes in others' conversations and/or activities	0	1	2	3	<input type="checkbox"/> <small>Coeff 26-36</small>	
IMPAIRMENT	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
A. Overall School Performance	1	2	3	4	5	
B. Reading	1	2	3	4	5	
C. Writing	1	2	3	4	5	
D. Mathematics	1	2	3	4	5	
E. Relationship with parents	1	2	3	4	5	
F. Relationship with siblings	1	2	3	4	5	
G. Relationship with peers	1	2	3	4	5	<input type="checkbox"/> <small>Coeff 41-56</small>
H. Participation in organized activities (e.g., teams)	1	2	3	4	5	<input type="checkbox"/> <small>Coeff 41-56</small>

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

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-Please Turn Over-

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

### Side-Effects Rating Scale

Instructions: Listed below are several possible negative effects (side effects) that medication may have on an ADHD child. Please read each item carefully and use the boxes to rate the severity of your child's side effects he/she has been on his/her current dose of medication. When requested, or wherever you feel it would be useful for us to know, please describe the side effects that you observed or any other unusual behavior in the "Comments" section below.

**Use the following to assess severity:**

- None:** The symptom is not present.
- Mild:** The symptom is present but is not significant enough to cause concern to your child, to you, or to his/her friends. Presence of the symptom at this level would NOT be a reason to stop taking the medicine.
- Moderate:** The symptom causes impairment of functioning or social embarrassment to such a degree that the negative impact on social and school performance should be weighed carefully to justify benefit of continuing medication must be considered.
- Severe:** The symptom causes impairment of functioning or social embarrassment to such a degree that the child should not continue to receive this medication or dose of medication as part of current treatment.

	None	Mild	Moderate	Severe
Motor: Tics—repetitive movements: jerking or twitching (e.g., eye blinking—eye opening, facial or mouth twitching, shoulder or arm movements)—describe below				
Buccal—lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/check biting—describe below				
Picking at skin or fingers, nail biting, lip or cheek chewing—describe below				
Worried/Anxious				
Dull, tired, listless				
Headaches				
Stomachache				
Crabby, Irritable				
Tearful, Sad, Depressed				
Socially withdrawn—decreased interaction with others				
Hallucinations (see or hear things that aren't there)				
Loss of appetite				
Trouble sleeping (time went to sleep)				

Adapted from the Pittsburgh Side-Effects Rating Scale

COMMENTS:



Please return this form via fax to 843-332-9894; if any academic concerns, please include report card

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NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: \_\_\_\_\_ Class Time: \_\_\_\_\_ Class Name/Period: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Please list if the student has an IEP, 504, BIP, or intervention team (such as A-team, SSS-team, or RT/response to intervention)

**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 last assessment scale was filed out. 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. 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

Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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

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Teacher's Name: \_\_\_\_\_ Class Time: \_\_\_\_\_ Class Name/Period: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

## For Office Use Only

Total Symptom Score for questions 1–18: \_\_\_\_\_

Average Performance Score: \_\_\_\_\_

Please return this form to: The Children's Group, P.C.Mailing address: 906 West Carolina Ave  
Hartsville, SC 29550Fax number: 843-332-9894

Adapted from the Pittsburgh side effect scale, developed by William E. Pithers, Jr, PhD.

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