



ADHD EVALUATION PACKET

In order to properly evaluate your child for attention and school difficulty we need to obtain the following information from both you and your child's teacher(s). Please submit all information together at least **2 WEEKS PRIOR** to the initial appointment to allow the provider time to review and interpret the information. If we do not receive this information we may ask you to reschedule the appointment, as we cannot do an adequate evaluation without the complete packet returned.

Included in this packet you will receive the following:

- For parents to complete -
 - **ADHD INITIAL PATIENT HISTORY** – *This history should be completed by a parent/guardian knowledgeable about the child/family's history.*
 - **VANDERBILT ASSESSMENT SCALE PARENT INFORMANT** – *Each parent/guardian should complete his/her own survey (copy as needed).*
- Give to your child's teacher(s) -
 - **AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION** – *This form should be completed by a parent/guardian and given to the teacher to allow information to be shared between the clinic and the teachers.*
 - **TEACHER QUESTIONNAIRE and VANDERBILT ASSESSMENT SCALE TEACHER INFORMANT** – *please give to each of your child's teacher(s) for them to complete (copy as needed).*

We will review this information with you and your child at the first appointment. Return completed forms to:

Kids First Pediatrics of Raleigh
23 Sunnybrook Rd Suite 116
Raleigh NC 27610
Phone : 919-250-3478
Fax: 919-250-6272

Kids First Pediatrics of Clayton
400 Athletic Club Blvd
Clayton NC 27527
Phone: 919-267-1499
Fax: 919-250-6272

Please be aware that several visits and further evaluation may be needed before a diagnosis of ADHD can be made or ruled out and treatment started.

Thank you,
Kids First Pediatrics

INITIAL PATIENT - SCHOOL HISTORY (FOR PARENTS TO FILL OUT)

CHILD'S NAME		NAME OF SCHOOL	
DATE OF BIRTH		GRADE LEVEL	

FORMS COMPLETED BY	
RELATIONSHIP TO CHILD	
DATE COMPLETED	

1. Please summarize your concerns:

2. When did these problems begin?

3. Please list any prior evaluations:

4. Please describe any concerns the teachers have mentioned to you:

5. Please describe your child's current services at school (i.e. tutors, special education classes):

INITIAL PATIENT - HOME HISTORY

1. Please describe any concerns you may have about your child at home:

2. Please describe your child's current overall mood:

3. Please describe any concerns about your child's esteem/confidence?

4. Please describe your child's homework habits:

5. Please describe your child's chores/responsibilities:

6. Please describe your child's listening skills:

7. Please describe your child's relationship with parents/siblings:

INITIAL PATIENT - HOME HISTORY (CONT.)

8. Please describe any trouble making or keeping friends:

9. Please describe any discipline strategies you may use:

10. With whom does the child live? If parents are divorced/separated, what are the custody and living arrangements?

11. Please describe any family stressors:

12. How often and for how long does your child watch TV/videos/video games?

13. What activities does your child participate in and how often (sports,music,religion,hobbies)?

NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's 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
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1. Does not pay attention to details or makes careless mistakes with, for example, homework				
---	--	--	--	--

2. Has difficulty keeping attention to what needs to be done				
--	--	--	--	--

3. Does not seem to listen when spoken to directly				
--	--	--	--	--

4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)				
---	--	--	--	--

5. Has difficulty organizing tasks and activities				
---	--	--	--	--

6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort				
---	--	--	--	--

7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)				
---	--	--	--	--

8. Is easily distracted by noises or other stimuli				
--	--	--	--	--

9. Is forgetful in daily activities				
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10. Fidgets with hands or feet or squirms in seat				
---	--	--	--	--

11. Leaves seat when remaining seated is expected				
---	--	--	--	--

12. Runs about or climbs too much when remaining seated is expected				
---	--	--	--	--

13. Has difficulty playing or beginning quiet play activities				
---	--	--	--	--

14. Is "on the go" or often acts as if "driven by a motor"				
--	--	--	--	--

15. Talks too much				
--------------------	--	--	--	--

16. Blurts out answers before questions have been completed				
---	--	--	--	--

17. Has difficulty waiting his or her turn				
--	--	--	--	--

18. Interrupts or intrudes in on others' conversations and/or activities				
--	--	--	--	--



Symptoms (continued) Never Occasionally Often Very Often

- 19. Argues with adults
20. Loses temper
21. Actively defies or refuses to go along with adults' requests or rules
22. Deliberately annoys people
23. Blames others for his or her mistakes or misbehaviors
24. Is touchy or easily annoyed by others
25. Is angry or resentful
26. Is spiteful and wants to get even

- 27. Bullies, threatens, or intimidates others
28. Starts physical fights
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)
30. Is truant from school (skips school) without permission
31. Is physically cruel to people
32. Has stolen things that have value
33. Deliberately destroys others' property
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)
35. Is physically cruel to animals
36. Has deliberately set fires to cause damage
37. Has broken into someone else's home, business, or car
38. Has stayed out at night without permission
39. Has run away from home overnight
40. Has forced someone into sexual activity

- 41. Is fearful, anxious, or worried
42. Is afraid to try new things for fear of making mistakes
43. Feels worthless or inferior
44. Blames self for problems, feels guilty
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"
46. Is sad, unhappy, or depressed
47. Is self-conscious or easily embarrassed

Performance Excellent Above Average Average Somewhat of a Problem Problematic

- 48. Reading
49. Writing
50. Mathematics
51. Relationship with parents
52. Relationship with siblings
53. Relationship with peers
54. Participation in organized activities (eg, teams)



Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

-
- Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.
 No tics present. Yes, they occur nearly every day but go unnoticed by most people. Yes, noticeable tics occur nearly every day.
 - Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, or repetition of words or short phrases.
 No tics present. Yes, they occur nearly every day but go unnoticed by most people. Yes, noticeable tics occur nearly every day.
 - If **YES** to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? No Yes
-

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

-
- | | | |
|--|-----------------------------|------------------------------|
| 1. Has your child been diagnosed with a tic disorder or Tourette syndrome? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Is your child on medication for a tic disorder or Tourette syndrome? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Has your child been diagnosed with depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Is your child on medication for depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Has your child been diagnosed with an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Is your child on medication for an anxiety disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Has your child been diagnosed with a learning or language disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
-

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 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 in questions 48–50: _____

Total number of questions scored 5 in questions 48–50: _____

Total number of questions scored 4 in questions 51–54: _____

Total number of questions scored 5 in questions 51–54: _____

To submit this form manually, save the form with your changes added, and email as an attachment to hello@kidsfirstraleigh.com

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

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. Original document included as part of *Caring for Children With ADHD: A Resource Toolkit for Clinicians*, 2nd Edition. Copyright © 2012 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™



400 Athletic Club Blvd Unit 101
Clayton, NC 27527
Phone : (919) 267-1499
Fax : (919) 250-6272



4109 Wake Forest Rd. STE 300
Raleigh, NC 27609
Phone : (919) 250-3478
Fax : (919) 250-6272

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION (Autorización para el intercambio de información de salud)

Patient Name (Nombre del paciente): _____

Date of Birth (Fecha de nacimiento): _____

Address (Dirección): _____

Telephone (Teléfono): _____

- I authorize the use or disclosure of the named individual's health information as described below
(Yo autorizo el uso o intercambio de información del paciente listado)
- The following individual(s) or organization(s) is authorized to make the disclosure
(La autorización médica facilita a la Compañía el obtener archivos médicos de cualquier proveedor)

CHECK ONE : Send TO Request FROM

Provider Name (Nombre del Proveedor): _____

Telephone (Teléfono): _____ - _____ - _____ Fax Number (Número de fax): _____ - _____ - _____

Address (Dirección): _____

- The type of information to be used or disclosed is as follows (check and /or include description):
(La información que será solicitada)
 - Immunization Record & Medical Summary / *Registro de Vacunas & Resumen Médico*
 - Records only from / *Registros de* ____/____/____ (date/fecha) to ____/____/____ (date/fecha)
 - Records pertaining to (please describe) /*Registros indicando solamente (por favor de especificar)* _____
- I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS-related syndrome or HIV testing. It may also include information about behavior or mental health services, alcohol, drug, psychiatric and psychological information.
(Entiendo que la información en mi registro de salud puede incluir información relacionada con el embarazo, enfermedades de transmisión sexual, SIDA, síndrome relacionado con el SIDA o pruebas de VIH. También puede incluir información psiquiátrica y psicológica.)

5. Release records for use by or disclose to the provided:

Kids First Pediatrics of Raleigh
4109 Wake Forest Rd. STE 300 Raleigh, NC 27609
Telephone: 919.250.3478 Fax: 919.250.6272

6. Disclosed information will be used for the following purposes:

- My personal records **(Mis registros personales)**
- Transfer of care, due to dissatisfaction with the practice **(Transferencia de cuidado, debido a la insatisfacción con la práctica)**
- Transfer of care due to relocation **(Transferencia de atención debido a la reubicación)**
- Other (please specify)/Otro **(por favor especificar)** _____

7. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

(Entiendo que una vez que se divulgue la información anterior, el destinatario podrá volver a divulgarse y es posible que ya no esté protegida por las normas de privacidad federales o estatales.)

8. I understand that I have the right to revoke this authorization at any time, by presenting a written revocation to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.

(Entiendo que tengo el derecho de revocar esta autorización en cualquier momento, presentando una revocación por escrito al Oficial de Privacidad. Entiendo que la revocación no se aplicará a la información que ya se ha divulgado en respuesta a esta autorización.)

9. This authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in ninety (90) days.

(Esta autorización caducará en la siguiente fecha o evento _____. Si no especifico una fecha de vencimiento o evento, esa autorización caducará en noventa (90) días.)

10. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form to assure healthcare or treatment.

(Entiendo que autorizar la divulgación de esta información de salud es voluntaria. No necesito firmar este formulario para asegurar atención médica o tratamiento.)

Signature/Firma _____ / _____ / _____
Patient or Legal Representative Relationship to patient Date
(Paciente o representante legal) (Relación con paciente) (Fecha)



ADHD EVALUATION PACKET

Dear Teacher/Counselor,

We are currently evaluating one of your students for concerns regarding ADHD. In order to complete this evaluation, we are asking you to complete the following questionnaire and rating scale. Each teacher should complete a separate questionnaire and survey. Once completed, please return the form to the parent as soon as possible so it can be returned to us. Alternatively, please fax the form to our office at the fax number listed below.

In addition to the questionnaire and survey, it would be helpful to receive copies of any evaluations done at school. These may include achievement tests, educational assessments, IEP reports, 504 plans, or school psychological reports.

A signed Authorization for Release/Exchange of Confidential Information by the parent/guardian is also enclosed.

Thank you for your assistance and cooperation in the completion of these forms. Please call if you have any questions regarding the enclosed material.

STUDENT'S NAME	
PARENT'S NAME	

Sincerely,

Kids First Pediatrics

Phone (Raleigh): 919-250-3478

Phone (Clayton): 919-267-1499

Fax: 919-250-6272

TEACHER QUESTIONNAIRE

STUDENT'S NAME	
STUDENT'S GRADE LEVEL	
DATE COMPLETED	

SCHOOL NAME	
TEACHER'S NAME	
SUBJECT TAUGHT	

1. How long have you known this student?

2. How many students are in the class?

3. How often is this student absent?

4. Has this student repeated/skipped any grades?

5. Has this student had any or planned to have any IQ or educational assessments? *(if so, please attach copy of most recent report)*

6. Does this student have an IEP? *(if so, please attach copy of most recent report)*

TEACHER QUESTIONNAIRE - (CONT.)

7. Please describe any special help/services this student receives in and out of the classroom:

8. Please describe this student's strengths and difficulties as you see them:

9. Please list any specific questions and/or areas in which you would like to help this student:

NICHQ Vanderbilt Assessment Scale: Teacher Informant

Child's Name: _____

Child's Date of Birth: _____

Teacher's Name: _____

Today's Date: _____

Class Time: _____

Class Name/Period: _____

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: _____.

Symptoms	Never	Occasionally	Often	Very Often
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1. Fails to give attention to details or makes careless mistakes in schoolwork				
--	--	--	--	--

2. Has difficulty sustaining attention to tasks or activities				
---	--	--	--	--

3. Does not seem to listen when spoken to directly				
--	--	--	--	--

4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)				
---	--	--	--	--

5. Has difficulty organizing tasks and activities				
---	--	--	--	--

6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
--	--	--	--	--

7. Loses things necessary for tasks or activities (school assignments, pencils, books)				
--	--	--	--	--

8. Is easily distracted by extraneous stimuli				
---	--	--	--	--

9. Is forgetful in daily activities				
-------------------------------------	--	--	--	--

For Office Use Only _____ /9

10. Fidgets with hands or feet or squirms in seat				
---	--	--	--	--

11. Leaves seat in classroom or in other situations in which remaining seated is expected				
---	--	--	--	--

12. Runs about or climbs excessively in situations in which remaining seated is expected				
--	--	--	--	--

13. Has difficulty playing or engaging in leisure activities quietly				
--	--	--	--	--

14. Is "on the go" or often acts as if "driven by a motor"				
--	--	--	--	--

15. Talks excessively				
-----------------------	--	--	--	--

16. Blurts out answers before questions have been completed				
---	--	--	--	--

17. Has difficulty waiting in line				
------------------------------------	--	--	--	--

18. Interrupts or intrudes in on others (eg, butts into conversations/games)				
--	--	--	--	--

For Office Use Only _____ /9



Symptoms (continued) Never Occasionally Often Very Often

- 19. Loses temper
20. Activity defies or refuses to comply with adults' requests or rules
21. Is angry or resentful
22. Is spiteful and vindictive
23. Bullies, threatens, or intimidates others
24. Initiates physical fights
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)
26. Is physically cruel to people
27. Has stolen items of nontrivial value
28. Deliberately destroys others' property

For Office Use Only /10

- 29. Is fearful, anxious, or worried
30. Is self-conscious or easily embarrassed
31. Is afraid to try new things for fear of making mistakes
32. Feels worthless or inferior
33. Blames self for problems; feels guilty
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"
35. Is sad, unhappy, or depressed

For Office Use Only /7

Academic Performance Excellent Above Average Average Somewhat of a Problem Problematic

- 36. Reading
37. Mathematics
38. Written expression

For Office Use Only 4s: /3

For Office Use Only 5s: /3

Classroom Behavioral Performance Excellent Above Average Average Somewhat of a Problem Problematic

- 39. Relationship with peers
40. Following directions
41. Disrupting class
42. Assignment completion
43. Organizational skills

For Office Use Only 4s: /5

For Office Use Only 5s: /5

Comments:

Please return this form to: Kids First Pediatrics
Mailing address:
Fax number: (919)250-6272 OR 1(866)224-0754



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 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 in questions 36–38: _____

Total number of questions scored 5 in questions 36–38: _____

Total number of questions scored 4 in questions 39–43: _____

Total number of questions scored 5 in questions 39–43: _____

To submit this form manually, save the form with your changes added, and email as an attachment to hello@kidsfirstraleigh.com

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

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. Original document included as part of *Caring for Children With ADHD: A Resource Toolkit for Clinicians*, 2nd Edition. Copyright © 2012 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

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