Patient Name: ____________________________

Appointment Date: ________________________

ADHD EVALUATION PACKET

In order to properly evaluate your child for attention and school difficulty we need to obtain the following information both from you and your child's educator(s). Please submit all information together at least 2 WEEKS PRIOR to the initial appointment in order to allow the physician 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 parent to complete-

- **ADHD INITIAL PATIENT HISTORY This history should be completed by a parent/guardian knowledgeable about the child/family's history.**
- **NICHQ 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 DISCLOSURE This form should be completed by a parent/guardian and given to the teacher(s) to allow information to be shared between the clinic and teachers.**
- **TEACHER QUESTIONNAIRE and NICHQ VANDERBILT ASSESSMENT SCALE- TEACHER INFORMANT please give to each of your child's teacher(s) for them to complete and collect in a confidential envelope once completed (copy as needed).**

Complete information at least 2 WEEKS PRIOR to your initial appointment in order for us to properly review and score the surveys. We will review this information with you and your child at the first appointment. Return completed forms to the clinic below:

Southdale Pediatric Associates, Ltd.
3955 Parklawn Ave., Suite 120
Attn: Medical Records
Edina, MN 55435
(952) 278-7000

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.

Sincerely,

Southdale Pediatric Associates

INITIAL PATIENT HISTORY

ADHD

Child's Name: ______________________________ Date of Birth: ____________

Form Completed by: ______________________________ Relationship to Child: ____________

Date Completed: ______________________________

PLEASE SUMMARIZE YOUR CONCERNS:

WHEN DID THESE PROBLEMS BEGIN?

PLEASE LIST ANY PRIOR EVALUATIONS DONE AND ATTACH RESULTS IF ABLE:

DATE	NAME OF EVALUATOR

INITIAL PATIENT HISTORY

SCHOOL

NAME OF SCHOOL________________________________ GRADE____________

PLEASE DESCRIBE YOUR CHILD'S CURRENT SERVICES THEY RECEIVE AT SCHOOL (i.e. tutors, special education classes, gifted services, etc). PLEASE ATTACH A COPY OF ANY IEP OR TESTING COMPLETED.

WHAT HAVE TEACHERS MENTIONED AND HOW HAVE THEY ADDRESSED THE FOLLOWING CONCERNS:

DOES YOUR CHILD HAVE ANY IN CLASSROOM INTERVENTIONS TO ADDRESS THE FOLLOWING?

BEHAVIOR? ________________________________

WORK COMPLETION/HOMEWORK? ________________________________

ACADEMIC PROGRESS? ________________________________

HANDWRITING/NEATNESS? ________________________________

CARELESS MISTAKES?________________________________

DISTRACTION/ATTENTION?________________________________

HAVE ANY OF THESE CONCERNS BEEN MENTIONED BY PRIOR TEACHERS?

WHAT IS YOUR CHILD'S CURRENT AFTER SCHOOL ARRANGEMENTS?

____

INITIAL PATIENT HISTORY

HOME

PLEASE DESCRIBE ANY CONCERNS YOU HAVE ABOUT YOUR CHILD AT HOME:

____

____

____

____

____

HOW WOULD YOU DESCRIBE YOUR CHILD'S CURRENT

OVERALL MOOD_______________________________

HOMEWORK HABITS_______________________________

CHORE RESPONSIBILITIES/COMPLETION_______________________________

LISTENING SKILLS_______________________________

SLEEP HABITS_______________________________

DIET_______________________________

RELATIONSHIP WITH PARENTS/SIBLINGS_______________________________

DISCIPLINE_______________________________

WITH WHOM DOES YOUR CHILD LIVE? (IF SIBLINGS, WHAT ARE THEIR AGES?)

____

____

____

PARENTS ARE □ MARRIED □ DIVORCED □ SEPARATED □ NEVER MARRIED

IF DIVORCED/SEPARATED, WHAT ARE CUSTODY AND LIVING ARRANGEMENTS?

WHAT ARE THE CURRENT FAMILY STRESSORS?

____

____

INITIAL PATIENT HISTORY

SOCIAL

ARE THERE ANY FRIENDSHIP CONCERNS? ANY TROUBLE MAKING OR KEEPING FRIENDS?

____

____

____

ARE THERE ANY CONCERNS REGARDING YOUR CHILD'S SELF ESTEEM/CONFIDENCE?

____

____

____

WHAT ORGANIZED ACTIVITIES DOES YOUR CHILD PARTICIPATE IN AND HOW OFTEN? (i.e. sports, music, religion, scouts)

____

____

____

HOW OFTEN AND FOR HOW LONG DOES YOUR CHILD WATCH TV/PLAY VIDEO GAMES?

____

____

WHAT DOES YOUR CHILD DO THAT HE/SHE FEELS GOOD ABOUT?

____

____

____

Southdale pediatric associates, ltd.

INITIAL PATIENT HISTORY

MEDICAL

HAVE YOU OR YOUR CHILD'S PHYSICIAN EVER HAD CONCERNS REGARDING THE FOLLOWING?

IF SO, AT WHAT AGE?

	YES	NO	AGE	COMMENTS
PREMATURE BIRTH				
DEVELOPMENT				
GROWTH				
WEIGHT LOSS				
WEIGHT GAIN				
HEAD SIZE				
SPEECH DEVELOPMENT				
UNDERSTANDING LANGUAGE				
MEMORY				
APPETITE				
SLEEP				
HEADACHES				
STOMACH ACHES				
RECURRENT VOMITING				
TICS				
FAINTING				
CHEST PAIN				
TROUBLE BREATHING				
ASTHMA				
DAY OR NIGHT STOOL ACCIDENTS				
DAY OR NIGHT URINE ACCIDENTS				
CONSTIPATION				
DIARRHEA				
HAIR LOSS				
SKIN CHANGES/BIRTHMARKS				
HEARING PROBLEMS				
VISION PROBLEMS				
HEAD INJURY/CONCUSSION				
ANXIETY				
DEPRESSION				
CHEMICAL DEPENDENCY				
OTHER (DESCRIBE)				

MEDICAL CONT'D

PLEASE LIST ANY CHRONIC OR SERIOUS MEDICAL CONCERNS:

DATE	MEDICAL CONCERNS

PLEASE LIST ANY HOSPITALIZATIONS OR SURGERIES:

DATE	HOSPITALIZATION/SURGERY

CURRENT MEDICATIONS (INCLUDING VITAMINS/HERBALS):

MEDICATION	DOSAGE/FREQUENCY

ALLERGIES TO MEDICATIONS, FOODS, POLLENS, ETC: ☐ NONE

IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO

Southdale pediatric associates, ltd.

INITIAL PATIENT HISTORY

FAMILY

HAS ANYONE IN THE FAMILY (PARENT, SIBLING, GRANDPARENT, AUNT, UNCLE, COUSIN) EVER HAD DIFFICULTY WITH THE FOLLOWING

	YES	NO	RELATION	COMMENTS
LEARNING PROBLEMS				
READING				
MATHEMATICS				
SPEECH				
REPEATED A GRADE				
GIFTED				
INTELLECTUAL DISABILITY				
BEHAVIOR PROBLEMS				
ADHD				
TROUBLE IN SCHOOL				
TROUBLE WITH THE LAW				
HIGH SCHOOL DROP OUT				
MENTAL HEALTH PROBLEMS				
DEPRESSION				
ANXIETY				
OBSESSIVE COMPULSIVE DISORDER				
SUICIDE ATTEMPT/COMPLETION				
PSYCHIATRIC HOSPITALIZATION				
DRUG/ALCOHOL ABUSE				
DIFFICULTY HOLDING A JOB				
MEDICAL PROBLEMS				
AUTISM/ASPERGER'S SYNDROME				
THYROID DISEASE				
TIC/TOURETTE'S DISORDER				
HEART PROBLEM				
SEIZURE				
GENETIC CONDITION				
OTHER				

ANY OTHER COMMENTS/CONCERNS?

Southdale pediatric associates, LTD.

Stimulant ADHD Medication Heart History

We are committed to providing patients with safe, high quality patient care. Stimulant drugs are known to increase a child's heart rate and blood pressure. These side effects are not considered to be dangerous for most children. However, those with underlying forms of congenital heart disease and/or arrythmias (irregular heartbeat) could be at an increased risk for serious complications due to stimulant drug use.

We make your child's safety our business. Please take the time to carefully answer the following cardiac history questions. Your clinician may suggest an ECG test (a brief and painless heart test) for your child. This is just one more way that we ensure your child is receiving the most up to date, comprehensive patient care available.

PATIENT HISTORY	Yes	No
History of fainting or dizziness	☐	☐
History of fainting or dizziness with exercise	☐	☐
Seizure	☐	☐
Rheumatic Fever	☐	☐
Chest pain or shortness of breathe with exercise	☐	☐
Unexplained, noticeable change in exercise tolerance	☐	☐
Palpitations, increased heart rate, or extra skipped heartbeats	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Viral illness while also having chest pains or palpitations	☐	☐
Adopted or unknown family history	☐	☐

FAMILY HISTORY	Yes	No
Sudden or unexplained death in someone young	☐	☐
Heart attack occurring before the age of 35	☐	☐
Sudden death during exercise or a drowning of a family member	☐	☐
Cardiac arrhythmias (irregular heart rhythms)	☐	☐
Cardiomyopathy (weak or enlarged heart)	☐	☐
Long QTS, Short - QT Syndrome	☐	☐
WPW (Wolff-Parkinson-White Syndrome)	☐	☐
Hypertropic Cardiomyopathy (enlarged heart muscle)	☐	☐
Event requiring resuscitation in family member less than 35 years old	☐	☐
Marfan Syndrome	☐	☐
Other heart related condition	☐	☐

Form completed by: ______________________ **Relationship to patient:** ______________

Signature: ______________________________________ **Date:** ______________

Clinic Use Only

Clinician Initials: __________ Clinician Signature ______________________ Date: __________

Form Reviewed

Clinician Initials: __________ Clinician Signature: ______________________ Date: __________
Clinician Initials: __________ Clinician Signature: ______________________ Date: __________
Clinician Initials: __________ Clinician Signature: ______________________ Date: __________

Vanderbilt ADHD Diagnostic Parent Rating Scale

Child's Name: **Parent's Name:**

Today's Date: **Date of Birth:** **Age:**

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 not on medication not sure

Behavior:	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 on instructions 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 games	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 comply with adult's 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. Often lies to get out of trouble, obtain goods or favors, or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is often 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
33. Deliberately destroys other's property	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale (DSM-5), Cont.

Child's Name: ______________________ **Parent's Name** ______________________

Today's Date: ____________ **Date of Birth:** ____________ **Age:** ______

Behavior:	**Never**	**Occasionally**	**Often**	**Very Often**
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Has been 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

Academic & Social Performance:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
1. Overall school performance	1	2	3	4	5
2. Reading	1	2	3	4	5
3. Writing	1	2	3	4	5
4. Mathematics	1	2	3	4	5
5. Relationship with parents	1	2	3	4	5
6. Relationship with siblings	1	2	3	4	5
7. Relationship with peers	1	2	3	4	5
8. Participation in organized activities (eq. teams)	1	2	3	4	5

How old was your child when you first noticed the behaviors?

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

1. **Motor Tics:** Rapid, repetitive movements such as eye-blinking grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, rapid kicks.

   No tics present. Yes, they occur nearly every day, but go unnoticed by most people. Yes, noticeable tics occur nearly every day.

2. **Phonic (Vocal) Tics**: Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, 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

3. 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: Please answer the following questions to the best of your knowledge.

1. Has the child been diagnosed with ADHD or ADD?	No	Yes
2. Is he/she on medication for ADHD or ADD?	No	Yes
3. Has the child been diagnosed with a Tic Disorder or Tourette's Disorder?	No	Yes
4. Is he/she on medication for Tic Disorder or Tourette's Disorder?	No	Yes

Adolescent Intake Form – For Children 12 Years and older

In anticipation of your upcoming appointment, we ask you to review the following questions. This information is kept confidential.

Please summarize your main concerns:

When did these difficulties begin?

How has this affected your relationship with your family?

How has this affected your relationship with your friends, classmates, team members, or coworkers?

Have you been given a diagnosis or treated for this condition in the past? □ Yes □ No
If yes, when and how was it treated?

At the time of your visit, your clinician will review your concerns in more detail. He/she will also be interested in your past medical history and your family history for those with similar difficulties.

Patients Name: DOB:

Date Completed:

Authorization for Disclosure of Protected Health Information

(Please sign and give to your child's teacher(s))

Child's Name ______________________ Birth Date ______________________

I hereby authorize the school below to release information to and receive assessment results from:

School ______________________

Contact Person ______________________ Title ______________________

Telephone # ______________________

Address ______________________

City ______________________ State ______________________ Zip ______________________

Information to be released to **Southdale Pediatric Associates, Ltd** at the clinic below:

3955 Parklawn Ave., Suite 120
Attn: Medical Records
Edina, MN 55435

Information being requested:

☑Teacher Questionnaire
☑NICHQ Vanderbilt Assessment
☑Recent psychometric, academic, any current IEP/504 plan in use and behavioral assessments
Other: ______________________

Signature ______________________ Relationship to Child ______________________

Address ______________________

City ______________________ State ______________________ Zip ______________________

Home Phone# ______________________ Work Phone# ______________________

CHILD'S NAME____

PARENT'S NAME ____

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 in a sealed confidential envelope as soon as possible so it can be returned to us.

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

A signed Authorization for Disclosure of Protected Health 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.

Sincerely,

Southdale Pediatric Associates

TEACHER QUESTIONNAIRE

Child's Name________________________________ Date Completed__________

School Name________________________________ Child's Grade____________

Teacher's Name______________________________ Subject Taught__________

Hours with child (daily average)____________________

Number of students in class ______________________

How long have you known this child? ______________

Is this child absent often? ________________________

Has this child repeated/skipped any grades? __________

Has this child had any or planned to have any IQ or educational assessments?__________

If so, what is the child's Full IQ_________ Verbal IQ_________ Performance IQ_________

Does this child have an IEP? ___________________ (if so please attach copy of most recent)

Please describe any special help/services this child receives in and outside of the classroom:

____

____

____

____

Southdale pediatric associates, ltd.

Please rate the child's ability in the following for his/her grade level:

	Failing	Below Average	Average	Above Average	Superior
Reading					
Arithmetic					
Spelling					
Handwriting					
Written Expression					
Overall academic achievement					
Social Interactions					

PLEASE DESCRIBE THIS CHILD'S STRENGTHS AND DIFFICULTIES AS YOU SEE THEM.

____

____

____

____

____

PLEASE LIST ANY SPECIFIC QUESTIONS AND/OR AREAS IN WHICH YOU WOULD LIKE TO HELP THIS CHILD.

____

____

____

ANY ADDITIONAL COMMENTS.

____

____

____

Vanderbilt ADHD Diagnostic
Teacher Rating Scale

Child's Name: ______ **Teacher's Name:** ______ **Teacher's Fax#** ______

Today's Date: ______ **School:** ______ **Grade:** ______

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 not on medication not sure

Behavior:	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 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 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 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 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 in 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 get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen things of nontrivial value	0	1	2	3
28. Deliberately destroys other's 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
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

Vanderbilt ADHD Diagnostic Teacher Rating Scale (DSM-5), Cont.

Child's Name: **Teacher's Name**

Today's Date: **School:** **Grade:**

Academic & Social Performance:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
1. Reading	1.	2.	3.	4.	5.
2. Writing	1.	2.	3.	4.	5.
3. Mathematics	1.	2.	3.	4.	5.
4. Relationship with peers	1.	2.	3.	4.	5.
5. Following directions	1.	2.	3.	4.	5.
6. Disrupting class	1.	2.	3.	4.	5.
7. Assignment Completion	1.	2.	3.	4.	5.
8. Organizational Skills	1.	2.	3.	4.	5.

Comments:

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

1. **Motor Tics:** Rapid, repetitive movements such as eye-blinking grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, rapid kicks.

   No tics present. Yes, they occur nearly every day, but go unnoticed by most people. Yes, noticeable tics occur nearly every day.

2. **Phonic (Vocal) Tics**: Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, 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

3. 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: Please answer the following questions to the best of your knowledge.

1. Has the child been diagnosed with ADHD or ADD?	No	Yes
2. Is he/she on medication for ADHD or ADD?	No	Yes
3. Has the child been diagnosed with a Tic Disorder or Tourette's Disorder?	No	Yes
4. Is he/she on medication for Tic Disorder or Tourette's Disorder?	No	Yes