



ADULT & PEDIATRIC MEDICAL HISTORY FORM

Name _____ Age _____ DOB _____

Right Handed Left Handed

Reason for Visit _____

Social History

Married Single Partner Same/Opposite Divorced Widowed

Cigarettes/Cigars Yes No _____ Packs per day
 Alcohol Yes No _____ drinks per day _____ per week
 Recreational Drugs Yes No name _____
 Caffeinated beverages Yes No _____ per day

What type of work do you do? _____ Do you do any heavy lifting at work? Yes No

Are you currently disabled? Yes No

List any allergies to medications, IV dye, or foods _____

Family History (list blood relative)

Epilepsy _____ High Cholesterol _____ Alcoholism _____
 Migraine _____ Heart Disease _____ Genetic Disease _____
 Mental illness _____ Stroke _____ Cancer _____
 Diabetes _____ Neuropathy _____ Tremor _____
 Parkinson's _____ Alzheimer's _____ Multiple Sclerosis _____
 Neuropathy _____ High Blood Pressure _____

Previous Hospitalizations

Year _____ Illness/operation _____ Where _____
 Year _____ Illness/operation _____ Where _____

List any prior significant injuries _____ How Long? _____

System Review/Past Medical History (Check problems you have now or in the past)					
General	Musculoskeletal	Neurologic	<input type="checkbox"/> Mental Illness	Skin	Endocrine
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Convulsion/seizure	Cardiovascular	<input type="checkbox"/> Rashes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chest pain/tightness	<input type="checkbox"/> Hives	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> numbness/ Tingling	<input type="checkbox"/> Headaches-severe	<input type="checkbox"/> Heart murmur	Gastrointestinal	<input type="checkbox"/> (Female) Day of last period
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Irregular pulse	<input type="checkbox"/> Loss Of appetite (recent)	Head, Ears, Nose, Throat
<input type="checkbox"/> Fever	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Tremor/shaking	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Difficult to swallow	<input type="checkbox"/> Sinus Pain
<input type="checkbox"/> fatigue	<input type="checkbox"/> Joint injury/Gout	Genitourinary	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hoarseness
Eyes	Respiratory	<input type="checkbox"/> No bladder control	<input type="checkbox"/> Palpitations	<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Failing vision	<input type="checkbox"/> Asthma/chronic cough	<input type="checkbox"/> Venereal Disease	Hematology	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Pneumonia/Pleurisy	Psychiatric	<input type="checkbox"/> Anemia	<input type="checkbox"/> Abdominal Pain	Sleep
<input type="checkbox"/> double or blurred	<input type="checkbox"/> Bronchitis/Emphysema	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Jaundice/hepatitis	<input type="checkbox"/> sleeping difficulty
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Depression	<input type="checkbox"/> contact with bodily fluids	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> snoring
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Exposure to HIV	<input type="checkbox"/> Constipation	

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____

Date Completed: _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

STOP-Bang questionnaire

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Snoring? Do you snore loudly (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired? Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Observed? Has anyone observed you stop breathing or choking/gasping during your sleep?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pressure? Do you have or are being treated for high blood pressure ?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body mass index more than 35 kg/m²?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age older than 50 years old?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neck size large? (measured around Adam's apple) For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gender = Male?
Scoring criteria:		
Low risk of OSA: Yes to 0 to 2 questions		
Intermediate risk of OSA: Yes to 3 to 4 questions		
High risk of OSA: Yes to 5 to 8 questions		

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading _____	_____
Watching TV _____	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	_____
As a passenger in a car for an hour without a break _____	_____
Lying down to rest in the afternoon when circumstances permit _____	_____
Sitting and talking to someone _____	_____
Sitting quietly after a lunch without alcohol _____	_____
In a car, while stopped for a few minutes in the traffic _____	_____

*****COMPLETE FOR ELEMENTARY AGE PATIENTS*****

Conners' Parent Rating Scale–Revised (S)

by C. Keith Conners, Ph.D.

Child's ID: _____ **Gender:** **M** **F**

Birthdate: _____ **Age:** _____ **School Grade:** _____
Month Day Year

Parent's ID: _____ **Today's Date:** _____
Month Day Year

Instructions: Below are a number of common problems that children have. Please rate each item according to your child's behavior in the last month. For each item, ask yourself, "How much of a problem has this been in the last month?", and check the best answer for each one. If none, not at all, seldom, or very infrequently, you would select 0. If very much true, or it occurs very often or frequently, you would select 3. You would select 1 or 2 for ratings in between. Please respond to each item.

	NOT TRUE AT ALL (Never, Seldom)	JUST A LITTLE TRUE (Occasionally)	PRETTY MUCH TRUE (Often, Quite a Bit)	VERY MUCH TRUE (Very Often, Very Frequent)
1. Inattentive, easily distracted	0	1	2	3
2. Angry and resentful	0	1	2	3
3. Difficulty doing or completing homework	0	1	2	3
4. Is always "on the go" or acts as if driven by a motor	0	1	2	3
5. Short attention span	0	1	2	3
6. Argues with adults	0	1	2	3
7. Fidgets with hands or feet or squirms in seat	0	1	2	3
8. Fails to complete assignments	0	1	2	3
9. Hard to control in malls or while grocery shopping	0	1	2	3
10. Messy or disorganized at home or school	0	1	2	3
11. Loses temper	0	1	2	3
12. Needs close supervision to get through assignments	0	1	2	3
13. Only attends if it is something he/she is very interested in	0	1	2	3
14. Runs about or climbs excessively in situations where it is inappropriate ..	0	1	2	3
15. Distractibility or attention span a problem	0	1	2	3
16. Irritable	0	1	2	3
17. Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework) .	0	1	2	3
18. Restless in the "squirmy" sense	0	1	2	3
19. Gets distracted when given instructions to do something	0	1	2	3
20. Actively defies or refuses to comply with adults' requests	0	1	2	3
21. Has trouble concentrating in class	0	1	2	3
22. Has difficulty waiting in lines or awaiting turn in games or group situations	0	1	2	3
23. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
24. Deliberately does things that annoy other people	0	1	2	3
25. Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	0	1	2	3
26. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
27. Easily frustrated in efforts	0	1	2	3

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

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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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:

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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: _____



D4 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

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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D4

NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

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	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Academic Performance					
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: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—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. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her 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	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

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D5

NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

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

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

Side Effects: Has your 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 for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr. PhD.

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D6 NICHQ Vanderbilt Assessment Follow-up—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 last assessment scale was filled 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	Excellent	Above Average	Average	Somewhat of a 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. Wolraich, MD.

Revised - 0303

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D6

NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

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: _____

Mailing address: _____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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*****COLLEGE STUDENT ADHD QUESTIONNAIRE*****

Date:		
Student Name:		Student Birthdate:
Name/location of high school you attended:		Yr of graduation: GPA:
How many years have you attended?		What is your current GPA?
Current academic standing: <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR <input type="checkbox"/> Graduate student: degree program :		
What is your current major? How many times have you changed majors?		
Where do you live? <input type="checkbox"/> dorm <input type="checkbox"/> sorority/fraternity house <input type="checkbox"/> on campus house <input type="checkbox"/> off campus housing <input type="checkbox"/> other (describe):		

Reason for this Evaluation - Please list the symptoms and impairments that led you to seek an ADHD evaluation. If you have been diagnosed with ADHD in the past, list your current most impairing symptoms off medication. Please include details of your concerns and those expressed by others (professors, roommates, parents and other significant adults in your life) (May continue on back of paper if more space needed.)

Have you ever been diagnosed with ADHD? Yes No If yes, how old were you?

Which type? ADHD, inattentive predominant type ADHD, combined type ADHD, hyperactive-impulsive predominant type

Who made the diagnosis? Psychologist Pediatrician Family MD Psychiatrist Other:

Which of the following were involved in making the diagnosis of ADHD? Clinical interview and observation Checklists by you Checklists by parents Checklists by teachers Psycho-educational testing Computerized testing other (specify):

Have you ever been diagnosed with a learning disability? Yes No If yes, please describe:

Please check the following items that were true for you **most or all of the time** during each period:

	ELEMENTARY SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL
Blurted out answers before the questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not sustain attention to schoolwork during classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talked excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble playing or doing leisure things quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acted or spoke without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fidgeted or got out of seat excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not give close attention to details, made careless mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Required disciplinary interventions, e.g. sat in front of the class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble organizing activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had problems with peers (eg difficulty waiting for turn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently lost things for tasks or activities (eg. books, assignments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not appear to be listening when spoken to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failed to finish schoolwork and chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did just enough to get by	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe details/examples of checked items in ELEMENTARY SCHOOL:

Describe details/examples of checked items in MIDDLE SCHOOL:

Describe details/examples of checked items in HIGH SCHOOL:

Medical History:

Current medical illness(es), if any:

Current medications, if any:

History of thyroid disease? No Yes Not sure

History of head injury with loss of consciousness? No Yes Not sure

Current sleep disorder? No Yes Not sure

- Trouble falling asleep? No Yes Not sure
- Difficulty staying asleep? No Yes Not sure
- Disrupted breathing or loud snoring during sleep? No Yes Not sure
- Dozing off during the day? No Yes Not sure
- Average amount of time before falling asleep _____ min
- Average # of hours of sleep per night _____ hrs

History of heart disease (palpitations, murmurs, congenital heart disease)? No Yes Not sure, If yes, please describe:

- Have you ever fainted? No Yes Not sure, If yes, please describe circumstances:
- Any family history of heart disease? No Yes Not sure, If yes, please describe:
- Have any family member died from heart disease before the age of 50? No Yes Not sure, If yes, please describe:

Any family history of ADHD? No Yes Not sure, If yes, please describe:

Any family history of learning disabilities? No Yes Not sure, If yes, please describe:

History of alcohol and drug use: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.) These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.) cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. (May continue on back of paper if more space needed.)

Driving/Legal History

How many motor vehicle crashes have you been involved with as a driver?

In how many of these were you "at fault"?

How many of these were caused by being inattentive or distracted?

How many traffic tickets (not including parking tickets) have you received?

How many parking tickets?

Has your driver's license ever been suspended? No Yes Not sure # DUI/DWI citations:

Have you had any legal problems other than moving violations/traffic tickets in the past? No Yes Not sure

If yes, please describe and give date/age:

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

In the past 6 months..... Please provide examples/details in the space below if indicating "Sometimes" "Often" or "Very Often"	Never	Rarely	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
3. How often do you have problems remembering appointments or obligations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
Examples/details:					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
10. How often do you misplace or have difficulty finding things at home or at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
11. How often are you distracted by activity or noise around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
13. How often do you feel restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					

14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
15. How often do you find yourself talking too much when you are in social situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
18. How often do you interrupt others when they are busy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
Is there any additional information that is relevant to the above situations? If so, please describe:					

Please list the medications you are currently taking or have taken most recently for ADHD:				
Name of medication/maximum dose	How long & age(s) while taking?	Was it effective?	What side effects, if any?	Why did you stop taking this?

Other past psychiatric history:
Have you ever been diagnosed with any of the following mental health conditions?
• Depression <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:
• Anxiety disorder <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:
• Bipolar disorder <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:
• Other (specify) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:

Which emotional / behavioral health medications (like antidepressants, mood stabilizers) have been prescribed for you?				
Name of medication/maximum dose	How long & age(s) while taking?	Was it effective?	What side effects, if any?	Why did you stop taking this?

SUBMIT FORM