## Assessment Package

The assessment of children with attention and behavioral disorders is complex and requires the collection and synthesis of information from many sources. We need your help to insure your child receives the most accurate evaluation.

Following you'll find several questionnaires and forms for you and your child's teacher to complete. Please return the completed forms to the office during your child's next visit.

We thank you for your cooperation. Please contact us if you have any additional questions. Below is your reminder checklist.

Complete the entire parent packet.

Complete the first two pages of the school packet and take to the teacher to complete. Have the teacher return the completed forms to you.

Return all of the completed forms to the office during your child's next visit.

Please call if any questions.

Indian Crest Pediatrics
9035 Wadsworth Pky. Suite 3000
Westminster, CO 80021
(303) 422-7677

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRES

To complete your child's evaluation, please complete the enclosed forms about your child and your family. Your timely completion of these forms will give us a much better understanding of your child's behavior and needs and allow us to conduct the comprehensive evaluation most efficiently. The instructions for filling out these forms are listed below. Please follow these as closely as possible.

**Who should complete these forms?**

Ideally, the parent who spends the most time with the child should complete these forms. If two or more parents/caretakers wish to complete these questionnaires, each should do so independently on separate forms. Additional parent forms are available upon request.

**What if my child is already on medication?**

If your child is now taking medication (e.g., Ritalin) for behavior management purposes, it is very likely that you observe his/her behavior both on and off medication. Please answer the attached questionnaires based on how you observe your child most of the time. Also, please let us know on what basis you responded by checking one of the following:

_____ My child does not take medication for behavior problems.

_____ My child takes medication, but my ratings reflect how he/she behaves when off medication.

_____ My child takes medication, and my ratings reflect how he/she behaves when on medication.

Please list any medications your child is taking:

_____

**Why do I have to answer questions about myself?**

When completing the questionnaires pertaining to yourself and other aspects of your family life, please keep in mind that we are trying to learn as much as we can about the home environment in which your child functions. Having such information allows us to make recommendations that maximize your child's behavior and performance both at home and at school.

Should you have any questions about these instructions, please feel free to call us. Once again, we thank you for completing these forms.

*PLEASE RETURN THIS FORM ALONG WITH THE COMPLETED QUESTIONNAIRE*

## D3 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 |



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

Revised - 1102

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

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

| Symptoms (continued) | Never | Occasionally | Often | Very Often |
|---|---|---|---|---|
| 33. Deliberately destroys others' property | 0 | 1 | 2 | 3 |
| 34. Has used a weapon that can cause serious harm (bat, knife, brick, gun) | 0 | 1 | 2 | 3 |
| 35. Is physically cruel to animals | 0 | 1 | 2 | 3 |
| 36. Has deliberately set fires to cause damage | 0 | 1 | 2 | 3 |
| 37. Has broken into someone else's home, business, or car | 0 | 1 | 2 | 3 |
| 38. Has stayed out at night without permission | 0 | 1 | 2 | 3 |
| 39. Has run away from home overnight | 0 | 1 | 2 | 3 |
| 40. Has forced someone into sexual activity | 0 | 1 | 2 | 3 |
| 41. Is fearful, anxious, or worried | 0 | 1 | 2 | 3 |
| 42. Is afraid to try new things for fear of making mistakes | 0 | 1 | 2 | 3 |
| 43. Feels worthless or inferior | 0 | 1 | 2 | 3 |
| 44. Blames self for problems, feels guilty | 0 | 1 | 2 | 3 |
| 45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her" | 0 | 1 | 2 | 3 |
| 46. Is sad, unhappy, or depressed | 0 | 1 | 2 | 3 |
| 47. Is self-conscious or easily embarrassed | 0 | 1 | 2 | 3 |

| Performance | Excellent | Above Average | Average | Somewhat of a Problem | Problematic |
|---|---|---|---|---|---|
| 48. Overall school performance | 1 | 2 | 3 | 4 | 5 |
| 49. Reading | 1 | 2 | 3 | 4 | 5 |
| 50. Writing | 1 | 2 | 3 | 4 | 5 |
| 51. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 52. Relationship with parents | 1 | 2 | 3 | 4 | 5 |
| 53. Relationship with siblings | 1 | 2 | 3 | 4 | 5 |
| 54. Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| 55. Participation in organized activities (eg, teams) | 1 | 2 | 3 | 4 | 5 |

**Comments:**

**For Office Use Only**

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Date of Evaluation _____

**CHILD INFORMATION**

Child's Name_____ Date of Birth_____ Age_____

Address_____
(Street) (City) (State) (Zip)

Home Phone ( )_____ Work Phone ( )_____Mom / Dad
(Circle One)

Child's School_____ Teacher's Name_____

School's Address_____
(Street) (City) (State) (Zip)

School Phone ( )_____ Child's Grade _____

Is child in Special Education? YES NO If so, what type? _____

Has there ever been any psychiatric hospitalization? YES NO. If Yes, please provide details on separate sheet.

Has there ever been a history of suicidal or homicidal thinking, currently or in the past? YES NO
If Yes, please provide details on separate sheet.

Please describe your purpose in seeking this evaluation. What concerns do you have? How have these concerns made themselves known: at work/school/home/relationships?

**FAMILY INFORMATION**

Mother's Name_____ Age_____ Education _____

Mother's Place of Employment _____

Type of Employment _____

Father's Name_____ Age_____ Education _____

Father's Place of Employment _____

Type of Employment _____

Is the Child adopted? YES NO If yes, age when adopted_____

Please list the name(s) and age(s) of all other children in the family.

DEVELOPMENTAL AND HEALTH HISTORY INFORMATION

## PREGNANCY AND DELIVERY

A. Length of pregnancy (e.g., full term or 40 weeks, 32 weeks, etc.) _____

B. Length of delivery (hours from initial labor pains to birth) _____

C. Mother's age when child was born _____

D. Child's Birth Weight _____

E. Did any of the following conditions occur during pregnancy / delivery?

| | No | Yes |
|---|---|---|
| 1. Bleeding | | |
| 2. Weight gain of more than 30 lbs | | |
| 3. Toxemia/Preeclampsia | | |
| 4. Rh factor incompatibility | | |
| 5. Frequent nausea or vomiting | | |
| 6. Serious illness or injury | | |
| Took prescription medication<br>a) If yes, name of medication(s) _____ | | |
| 8. Took illegal drugs | | |
| 9. Used alcoholic beverages<br>a) If yes, approximate # of drinks per week _____ | | |
| 10. Smoked cigarettes<br>a) If yes, approximate # of cigarettes per week _____ | | |
| 11. Was given medication to ease labor pains<br>a) If yes, name of medication _____ | | |
| 12. Delivery was induced | | |
| 13. Forceps were used during delivery | | |
| 14. Had a breech delivery | | |
| 15. Had a cesarean section delivery | | |
| 16. Other problems...please describe_____ | | |

F. Did any of the following affect your child during delivery or within the first few days after birth?

| | No | Yes |
|---|---|---|
| 1. Injured during delivery | | |
| 2. Cardiopulmonary distress during delivery | | |
| 3. Delivered with cord around neck | | |
| 4. Had trouble breathing following delivery | | |
| 5. Needed oxygen | | |
| 6. Was cyanotic, turned blue | | |
| 7. Was jaundiced, turned yellow | | |
| 8. Had an infection | | |
| 9. Had seizures | | |
| 10. Was given medications | | |
| 11. Born with a birth (congenital) defect | | |
| 12. Was in hospital more than 7 days | | |

INFANT HEALTH AND TEMPERAMENT

A. During the first 12 months, was your child:

| | No | Yes |
|---|---|---|
| 1. Difficult to feed | | |
| 2. Difficult to get to sleep | | |
| 3. Colicky | | |
| 4. Difficult to put on a schedule | | |
| 5. Not alert | | |
| 6. Not cheerful | | |
| 7. Not affectionate | | |
| 8. Not sociable | | |
| 9. Not easy to comfort | | |
| 10. Difficult to keep busy | | |
| 11. Overactive, in constant motion | | |
| 12. Very stubborn, challenging | | |

**EARLY DEVELOPMENTAL MILESTONES**

A. At what age did your child first accomplish the following

| | Years | Months |
|---|---|---|
| 1. Sitting without help | | |
| 2. Crawling | | |
| 3. Walking alone, without assistance | | |
| 4. Using single words (e.g., mama, dada, ball, etc.) | | |
| 5. Putting two or more words together (e.g., mama up) | | |
| 6. Bladder Training - Day | | |
| 7. Bladder Training - Night | | |
| 8. Bowel Training – Day | | |
| 9. Bowel Training - Night | | |

HEALTH HISTORY

At any time has your child had:

| | NEVER | PAST | PRESENT |
|---|---|---|---|
| 1. Asthma | | | |
| 2. Allergies | | | |
| 3. Diabetes, Arthritis, or other chronic illness | | | |
| 4. Epilepsy or seizure disorder | | | |
| 5. Febrile seizures | | | |
| 6. Chicken pox or other common childhood illness | | | |
| 7. Heart or blood pressure problems | | | |
| 8. High fever (over 103) | | | |
| 9. Broken Bones | | | |
| 10. Severe cuts requiring stitches | | | |
| 11. Head injury with / without loss of consciousness | | | |
| 12. Lead poisoning | | | |
| 13. Surgery | | | |
| 14. Lengthy hospitalization | | | |
| 15. Speech or language problems | | | |
| 16. Chronic ear infections | | | |
| 17. Hearing difficulties | | | |
| 18. Ear or vision problems | | | |

| | NEVER | PAST | PRESENT |
|---|---|---|---|
| 19. Fine motor/handwriting problems | | | |
| 20. Gross motor difficulties, clumsiness | | | |
| 21. Appetite problems (overeating or undereating) | | | |
| 22. Wetting / Soiling problems | | | |
| 23. Other health difficulties...please describe | | | |

C. Pediatric Sleep Questionnaire

| Does your child... | No | Yes |
|---|---|---|
| 1. Snore more than half the time? | | |
| 2. Have heavy or loud breathing? | | |
| 3. Always snore? | | |
| 4. Snore loudly? | | |
| 5. Have trouble breathing or struggle to breath? | | |
| 6. Stop breathing during the night? | | |
| 7. Tend to breath through the mouth during the day? | | |
| 8. Have a dry mouth on waking up in the morning? | | |
| 9. Occasionally wet the bed? | | |
| 10. Wake up un-refreshed in the morning? | | |
| 11. Have a problem with sleepiness during the day? | | |
| 12. Has a teacher or other supervisor said your child appears sleepy during the day? | | |
| 13. Is it hard to wake your child in the morning? | | |
| 14. Does your child wake up with headaches in the morning? | | |
| 15. Did your child stop growing at a normal rate at any time since birth? | | |
| 16. Is your child overweight? | | |
| 17. Does your child complain of restless / achy legs when asleep? | | |
| 18. Does your child have repetitive "twitching" of the arms or legs during sleep? | | |
| 19. Does your child have frequent nightmares (more than once a week) that disturb him/her during the day? | | |

## B. Short Sensory Profile

Directions – Please circle the number that best describes the frequency with which your child does the following behaviors using the following scale:
Always – When presented with the opportunity, your child responds in this manner 100% of the time.
Frequently – When presented with the opportunity, your child responds in this manner 75% of the time.
Occasionally – When presented with the opportunity, your child responds in this manner 50% of the time.
Seldom – When presented with the opportunity, your child responds in this manner 25% of the time.
Never – When presented with the opportunity, your child responds in this manner 0% of the time.
Please answer all of the statements. If you are unable to comment because you have not observed the behavior or believe that it does not apply to your child, please draw an X through the number for that item

| Item | Tactile Sensitivity | Always | Frequently | Occasionally | Seldom | Never |
|---|---|---|---|---|---|---|
| 1 | Expresses distress during grooming (for example, fights or cries during haircutting, face washing) | 1 | 2 | 3 | 4 | 5 |
| 2 | Prefers long-sleeved clothing when it is warm or short sleeves when it is cold. | 1 | 2 | 3 | 4 | 5 |
| 3 | Avoids going barefoot in sand or grass | 1 | 2 | 3 | 4 | 5 |
| 4 | Reacts emotionally or aggressively to touch | 1 | 2 | 3 | 4 | 5 |
| 5 | Withdrawals from splashing water | 1 | 2 | 3 | 4 | 5 |
| 6 | Has difficulty standing in line or close to other people | 1 | 2 | 3 | 4 | 5 |
| 7 | Rubs or scratches out a spot that has been touched | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Taste/Smell Sensitivity | Always | Frequently | Occasionally | Seldom | Never |
| 8 | Avoids certain tastes or food smells that are typically part of children's diets | 1 | 2 | 3 | 4 | 5 |
| 9 | Will only eat certain tastes (list: ) | 1 | 2 | 3 | 4 | 5 |
| 10 | Limits self to particular food textures / temperatures (list: ) | 1 | 2 | 3 | 4 | 5 |
| 11 | Picky eater, especially regarding food textures | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Movement Sensitivity | Always | Frequently | Occasionally | Seldom | Never |
| 12 | Becomes anxious or distressed when feet leave the ground | 1 | 2 | 3 | 4 | 5 |
| 13 | Fears falling or heights | 1 | 2 | 3 | 4 | 5 |
| 14 | Dislikes activities where head is upside down (for example, ommersaults) | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Underresponsive/Seeks Sensation | Always | Frequently | Occasionally | Seldom | Never |
| 15 | Enjoys strange noises/seeks to make noise for noise's sake | 1 | 2 | 3 | 4 | 5 |
| 16 | Seeks all kinds of movement and this interferes with daily routines (for example, can't sit still) | 1 | 2 | 3 | 4 | 5 |

| Item | Underresponsive/Seeks Sensation (Continued) | Always | Frequently | Occasionally | Seldom | Never |
|---|---|---|---|---|---|---|
| 17 | Becomes overly excitable during movement activity | 1 | 2 | 3 | 4 | 5 |
| 18 | Touches people and objects | 1 | 2 | 3 | 4 | 5 |
| 19 | Doesn't seem to notice when hands or face are messy | 1 | 2 | 3 | 4 | 5 |
| 20 | Jumps from one activity to another so that it interferes with play | 1 | 2 | 3 | 4 | 5 |
| 21 | Leaves clothes twisted on body | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Auditory Filtering | Always | Frequently | Occasionally | Seldom | Never |
| 22 | Is distracted or has trouble functioning if there is a lot of noise around. | 1 | 2 | 3 | 4 | 5 |
| 23 | Appears not to hear what you say (fdoes not tune in to what you say) | 1 | 2 | 3 | 4 | 5 |
| 24 | Can't work with background noise (for example, fan, refrigerator) | 1 | 2 | 3 | 4 | 5 |
| 25 | Has trouble completing tasks when the radio is on | 1 | 2 | 3 | 4 | 5 |
| 26 | Doesn't respond when name is called but you know the child's hearing is OK | 1 | 2 | 3 | 4 | 5 |
| 27 | Has difficulty paying attention | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Low Energy/Weak | Always | Frequently | Occasionally | Seldom | Never |
| 28 | Seems to have weak muscles | 1 | 2 | 3 | 4 | 5 |
| 29 | Tires easily, especially when standing or holding particular body position | 1 | 2 | 3 | 4 | 5 |
| 30 | Has a weak grasp | 1 | 2 | 3 | 4 | 5 |
| 31 | Can't lift heavy objects (fweak in comparison to same age children) | 1 | 2 | 3 | 4 | 5 |
| 32 | Props to support self (even during activity) | 1 | 2 | 3 | 4 | 5 |
| 33 | Poor endurance / tires easily | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |
| Item | Visual/Auditory Sensitivity | Always | Frequently | Occasionally | Seldom | Never |
| 34 | Responds negatively to unexpected or loud noises | 1 | 2 | 3 | 4 | 5 |
| 35 | Holds hands over ears to protect ears from sound | 1 | 2 | 3 | 4 | 5 |
| 36 | Is bothered by bright lights after other have adapted to the light | 1 | 2 | 3 | 4 | 5 |
| 37 | Watches everyone when they move around the room | 1 | 2 | 3 | 4 | 5 |
| 38 | Covers eyes or squints to protect eyes from light | 1 | 2 | 3 | 4 | 5 |
| | Section Raw Score | | | | | |

## SCHOOL HISTORY

A. Preschool Experience

| Has child ever attended: | NEVER | PREVIOUSLY | PRESENTLY |
|---|---|---|---|
| 1. Early Intervention | | | |
| 2. Day Care | | | |
| 3. Head Start Program | | | |
| 4. Regular Preschool | | | |
| 5. Developmental Preschool | | | |
| 6. Special Education Preschool | | | |

B. School Performance & Behavior

| | P | K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Undergone Testing | | | | | | | | | | | | | | |
| 2. Had IEP / SPED | | | | | | | | | | | | | | |
| 3. Been labeled LD | | | | | | | | | | | | | | |
| 4. Worked < Potential | | | | | | | | | | | | | | |
| 5. Failed a subject | | | | | | | | | | | | | | |
| 6. Repeated a grade | | | | | | | | | | | | | | |
| 7. Been suspended | | | | | | | | | | | | | | |
| 8. Been expelled | | | | | | | | | | | | | | |

C. Current Educational Program

1. What is current grade level? _____

2. Now on an IEP or receiving SPED services? NO YES

| If yes, what type | NO | YES |
|---|---|---|
| a) Resource room (part-time) | | |
| b) Self-contained LD room (full-time) | | |
| c) Behavior disorders classroom | | |
| d) Speech/language therapy | | |
| e) Occupational therapy | | |
| f) Physical therapy | | |
| g) Social skills group therapy or other school counseling | | |

**FAMILY HISTORY**

A. Family Composition

1. Number of children in immediate family _____
2. Birth position in immediate family _____
3. Nature of relations with siblings

a. Below Average b. Average c. Above Average

B. Composition of Household

| Currently living with: | NO | YES |
|---|---|---|
| 1. Biological Mother | | |
| 2. Biological Father | | |
| 3. Step-parent | | |
| 4. Adoptive Parents | | |
| 5. Foster Parents | | |
| 6. Biological parent's significant other | | |
| 7. Full Sibling | | |
| 8. Half-sibling / Step-Sibling | | |
| 9. Other relatives / friends | | |

C. Marriage/Caretaker Relationship

1. Stability of parents' current marriage / relationship:

a) Generally stable b) Sometimes unstable c) Often unstable

D. Biological Parents

1. Child's biological parents:

a) Never were married, but still together
b) Never were married, now apart
c) Currently married
d) Once married, now separated
e) Once married, now divorced
f) Once married, now widowed

2. Number of years biological parents married / together _____
3. Custody of child is held:

a. Jointly b. By father only e. Other
b. By mother only d. By DSS

E. Recent Lifestyle Changes/Psychosocial Stressors

1. Over the past year, have there been any major lifestyle changes or stresses affecting the immediate family?

| | NO | YES |
|---|---|---|
| a. Pregnancy | | |
| b. New Sibling | | |
| c. Marriage | | |
| d. Marital tensions | | |
| e. Separation / Divorce | | |
| f. Medical Problems | | |
| g. Psychiatric Problems | | |
| h. Death of relative / friend | | |
| i. Change in residence | | |
| j. Change in work schedules | | |
| k. Job termination / layoff | | |
| l. Serious financial problems | | |
| m. Legal Problems | | |
| n. Other | | |

## MOOD/AFFECT/PSYCHIATRIC STATUS

A. Predominant Mood: What mood is your child in most of the time?

1. Cheerful / Happy 2. Sad/Depressed 3. Nervous/Anxious 4. Angry/Irritable

B. Stability of Mood: Do your child's moods change frequently, abruptly, and/or unpredictably?

1. Yes 2. No

C. Range of Affect: Is your child's range of emotional expression extremely limited? (robot-like?)

1. Yes 2. No

D. Appropriateness of Affect: Does your child often show inappropriate emotional reactions?

1. Yes 2. No

E. Other Concerns:

| Any evidence of: | NEVER | PAST | PRESENT |
|---|---|---|---|
| 1. Loose Thinking | | | |
| 2. Disoriented, Confused | | | |
| 3. Delusions | | | |
| 4. Hallucinations | | | |
| 5. Diminished interest in peers | | | |
| 6. Self-injurious behaviors | | | |
| 7. Self-stimulation | | | |
| 8. Alcohol Abuse | | | |
| 9. Substance Abuse | | | |
| 10. Cigarette Smoking | | | |
| 11. Physical Abuse | | | |
| 12. Sexual Abuse | | | |

## PEER RELATIONS

A. Making Friends: Does your child have problems making friends?

1) Almost Never 2) Some of the time 3) Most of the time

B. Keeping Friends: Does your child have problems keeping friends?

1) Almost Never 2) Some of the time 3) Most of the time

C. Peer Group Age Range: How old are most of your child's friends?

1) Younger 2) Same Age 3) Older

D. Number of Close Friends: How many close friends does he/she have?

1) None 2) Just a Few 3) Lots

E. Peer Interaction Style: When your child plays with other children, is he/she often...?

1) Inattentive, spacey
2) Bossy, controlling, aggressive
3) Combination of 1 & 2
4) Shy, reserved, withdrawn
5) Appropriate for age

F. Peer Conflict Resolution: When your child has disagreements or conflicts with other children, how well does he/she resolve such situations?

1) Not very well 2) Moderately well 3) Very well

G. Conflict Resolution Style: What does your child usually do to resolve conflicts?

1) Compromises, bargains
2) Gives in to others
3) Threatens, bullies, fights
4) Asks an adult for help
5) Avoids conflict

H. Peer Acceptance: Do most children...?

1) Accept/enjoy being with your child
2) Overtly reject/tease your child
3) Avoid/ignore your child

I. Child's Self-Perception: How does your child feel about his/her relations with other children?

1) Generally happy and satisfied
3) Occasionally dissatisfied
4) Often upset and distressed

## CHILD'S EVALUATION & TREATMENT HISTORY

A. Prior Evaluation/Diagnoses

| Has child ever undergone: | NO | YES |
|---|---|---|
| 1. Psychiatric Evaluation | NO | YES |
| 2. Pediatric Assessment | NO | YES |
| 3. Neurological Work-up | NO | YES |
| 4. Dietary Analysis | NO | YES |
| 5. Intelligence Testing | NO | YES |
| 6. Psycho educational Testing | NO | YES |
| 7. Speech/Language/Hearing Evaluation | NO | YES |
| 8. Neuropsychological Testing | NO | YES |
| 9. Previously established diagnosis of ADHD | NO | YES |

B. Psychological / Psychiatric Treatment

| Has child ever received: | NEVER | PREVIOUSLY | PRESENT |
|---|---|---|---|
| 1. Individual Therapy | | | |
| 2. Play Therapy | | | |
| 3. Family Therapy | | | |
| 4. Group Therapy | | | |
| 5. Brief Inpatient Treatment | | | |
| 6. Residential Treatment | | | |
| 7. Behavioral Parent Training | | | |
| 8. Social Skills Training | | | |

C. Pharmacotherapy

| Has child ever taken: | NEVER | PREVIOUS | PRESENT |
|---|---|---|---|
| 1. Ritalin | | | |
| 2. Dexedrine | | | |
| 3. Concerta | | | |
| 4. Adderall | | | |
| 5. Strattera | | | |
| 6. SSRI (Prozac, Zoloft, Paxil, Celexa, Lexipro) | | | |
| 7. Wellbutrin | | | |
| 8. Zyprexa | | | |
| 9. Other Antideressant _____ | | | |
| 10. Clonidine | | | |
| 11. Anticonvulsant | | | |
| 12. Antihistamine | | | |
| 13. Major Tranquilizer | | | |
| 14. Other | | | |

15. If currently taking psychotropic medication...total daily dosage(s) _____

16. How often?

a) 5 days/week – school year

b) 7 days/week – school year

c) 7 days/week – year round

17. Any improvement

a) None at all b) Somewhat c) Very much

18. Any side effects?

a) None at all b) Some c) Many

19. Does your child take prescribed medication for any other reason?

a) No b) Yes _____

_____

(list name, dosage, reason)

D. Other Forms of Treatment / Support Services

| Has your child ever tried: | NEVER | PREVIOUS | PRESENT |
|---|---|---|---|
| 1. Dietary changes | | | |
| 2. Neurofeedback | | | |
| 3. Parent Support Group | | | |
| 4. Other | | | |

Psychiatric / Medical Characteristics of Biological Relatives

| Past/Present Hx of: | Siblings | Mother | Father | Extended Maternal | Extended Paternal |
|---|---|---|---|---|---|
| 1. AD/HD symptoms / diagnosis | | | | | |
| 2. ODD symptoms / diagnosis | | | | | |
| 3. Conduct Disorder symptoms / diagnosis | | | | | |
| 4. Antisocial behavior | | | | | |
| 5. LD symptoms / diagnosis | | | | | |
| 6. Mental Retardation | | | | | |
| 7. Psychosis / Sx | | | | | |
| 8. Bipolar Disorder | | | | | |
| 9. Depression/Suicide | | | | | |
| 10. Anxiety Disorders | | | | | |
| 11. Phobias | | | | | |
| 12. Tics / Tourettes | | | | | |
| 13. Alcohol Abuse | | | | | |
| 14. Substance Abuse | | | | | |
| 15. Physical Abuse | | | | | |
| 16. Sexual Abuse | | | | | |
| 17. Seizures / Epilepsy | | | | | |
| 18. Other medical | | | | | |
| 19. Other psychiatric | | | | | |
| 20. Outpatient psych tx | | | | | |
| 21. Inpatient Psych tx | | | | | |

## HOME MANAGEMENT

A. Compliance

1. How often does your child do what you ask on the first request?

   a) Almost Never  b) Some of the Time  c) Most of the Time

2. How often does your child eventually do what you want them to do?

   a) Almost Never  b) Some of the Time  c) Most of the Time

B. Strategies

| Have you used: | NEVER | PREVIOUS | PRESENT |
|---|---|---|---|
| 1. Privilege Removal | | | |
| 2. Isolation / Time Out | | | |
| 3. Grounding | | | |
| 4. Spanking / Physical Punishment | | | |
| 5. Verbal Reprimands | | | |
| 6. Allowance System | | | |
| 7. Special Privileges / Rewards | | | |
| 8. Star Chart / Token System | | | |
| 9. Verbal Praise | | | |
| 10. Other: | | | |

C. Parenting Effectiveness / Consistency

1. Overall, how effectively do you manage your child's behavior?

   a) Not very well  b) Moderately well  c) Very well

2. Overall, how effectively does your spouse/partner manage your child's behavior?

   a) Not very well  b) Moderately well  c) Very well

3. Do you & your spouse/partner generally agree on which behaviors to discipline?

   a) Almost never  b) Some of the time  c) Most of the time

4. Do you & your spouse/partner generally agree on how to discipline?

   a) Almost never  b) Some of the time  c) Most of the time

PLEASE INCLUDE ANY ADDITIONAL COMMENTS BELOW AND ON THE NEXT PAGE: