Lafayette
Pediatric Clinic

Tanya Fitts, M.D.
BOARD CERTIFIED IN PEDIATRICS
Donica Long, FNP-C

Dear Parent(s):

Enclosed is the ADHD packet you requested for your child. Included in the packet are questionnaires for you, as well as for your child's teacher(s) to complete. If your child is of middle school age or older, it is necessary to have completed questionnaires from at least two teachers to facilitate proper diagnosis of your child. In order to adequately score and evaluate the information, we will need the questionnaires and any school evaluations returned before an appointment is made.

Please be aware there are additional charges involved in the scoring and evaluation of these questionnaires. These charges will be added to the office visit charge on the date of the visit. Some insurance plans do not cover these charges or may apply them to your deductible. In those cases, the charges will be your out-of-pocket responsibility. Fee free to contact our billing office if you have questions about what your insurance plan covers.

Thank you for your cooperation in completing and returning the packet to our office. Once we have received the questionnaires, we will contact you to make the appointment for the ADHD evaluation. In the meantime, please do not hesitate to call, (662) 236-3939 if you have any further questions.

Sincerely,

Lafayette Pediatric Clinic

1300 Access Road, Ste. 400 Oxford, MS 38655 | tel: 662.236.3939 fax: 662.236.3924
LAFAYETTEPEDIATRICS.NET

Lafayette
Pediatric Clinic

ADHD Initial Parent Questionnaire

Child's Name:_____ DOB:_____ Age:_____ Today's Date:_____

Name of Person Completing Form: _____ Relationship: _____

In your own words, what is the reason for this evaluation?:_____

_____

_____

When did you first notice these issues?_____

Concerns or delays during early years with development, behavior, or sensory processing? If so, any therapy (like physical therapy, occupational therapy, or speech therapy):_____

_____

_____

List any previous school, developmental, or mental health evaluations for the child—when, where, results:

_____

_____

Please list any services provided by school staff, tutors, or other professionals (OT, PT, speech) currently involved with your child AND any educational plans in place (IEP, 504):

_____

_____

Is your child currently receiving counseling or therapy with a psychologist, psychiatrist, social worker, or other professional? _____

Is or has your child ever taken any medication for an emotional, behavioral, or mental health problem? If so, what and when? Include herbal and over the counter medication: _____

_____

Medical History

Please give approximate dates and a brief explanation of any of the following:

Problems during pregnancy, delivery, or early infancy: _____

_____

Hospitalizations, serious illness, surgeries, serious injury: _____

_____

Previously detected heart disease or condition, palpitations, fainting, or seizures: _____

_____

Concussion, skull fracture, or serious head injury:_____

Sleep History

Time goes to/put to bed: _____ Time falls asleep: _____ Difficulty falling asleep? _____

Where does child sleep :_____

Time awakens/gets out of bed: _____ Difficult to awaken? _____

Describe difficulties your child has with sleep:_____

_____

School & Social Skills

What are your child's best subjects in school? _____

Does your child need extra help with homework? _____ Behavior problems in classroom(describe): _____

_____

How well does your child get along with brothers & sisters?_____
What about with other kids the same age? _____
How easily does your child make friends?_____
Would you describe your child as shy? anxious?_____

Does your child have behavior problems at lunch/recess (describe):_____

_____

Temperament & Sensory Issues

Does your child have any areas of extreme interest (dinosaurs, sports teams, weapons)? _____

Is this interest positive and productive? _____ Or over-focused/excessive?_____

How does your child react to teasing or if things don't go his way? _____

Does your child have melt-downs over relatively insignificant issues? _____

As a baby, what was your child's usual temperament or personality? _____

□Easy - didn't cry much, slept and ate on schedule, cuddly, easy to soothe

□Average - usually somewhere between easy and difficult

□Sensitive - easily upset, best with a fixed schedule, but cuddly, easy to soothe

□Difficult - hard to satisfy, fussy, did not eat/sleep on schedule, colicky

Did your child's personality stay this way into preschool and beyond? Yes No

Family

Having a complete picture of your family's life allows us to determine the best way to help your child.

Who lives in home:_____
Mother's highest grade completed/occupation:_____
Father's highest grade completed/occupation:_____
If divorced/separated, describe custody arrangements:_____
Describe any of following issues your family is facing - health, marital, work, relative, friends, personal/emotional:

_____

Stressful Family Events:

Check any of the following events that may have occurred in the past 12 months:

Family moved		Parents divorced or separated		Food availability		Child saw abuse or another sexual situation
Tension in the home		Car accident		Child changed schools/daycare		Concern about housing
Legal or financial issues		Loss of a close friend		House fire, natural disaster		Other:
Death of a pet; new pet		Someone new in the household		Family member was a crime victim		Other
Family member ill or injured		Absence of parent for a week +		Parent changed/lost job		Other:

Stressful Child Events

Has your child been the victim of:

Physical abuse		Sexual Abuse		Life threatening experience (fire, accident, etc.)	
Emotional or Verbal Abuse		Bullying		Separation from parents for a week +	
Crime		Harassment at school		Other:	
Witnessed violence in the home		Witnessed crime in the community		Not Sure	

Family History

Indicate any relatives of the child with any of the following problems:

Problem List	Siblings	Natural Mother	Natural Father	Mother's relatives	Father's relatives
Serious or chronic medical problems: **cardio**, cancer, deafness, heart problems, seizures, diabetes, etc.					
Obsessive-Compulsive disorder or fussy habits, picky, rigid					
Tics or other nervous habits, Tourette's					
Depression for more than 2 weeks, medications for mood disorder					
Suicide or attempted suicide					
Psychosis or schizophrenia, hospitalized for mental or mental or emotional problems					
Alcohol or drug abuse					
Legal problems, arrests, jail/prison time, court probations, etc.					
Gambling, shopping or other compulsions					

American Academy of Pediatrics

CLEAR FORM

CLINICIAN TOOLS

ADHD

Vanderbilt Assessment Scale: *ADHD Toolkit* Parent-Informant Form

Child's name: _____ Parent's name: _____

Date: _____ DOB: _____ 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.

This evaluation is based on a time when your child: ☐ Was on medication ☐ Was not on medication ☐ Not sure

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
1. Does not pay attention to details or makes mistakes that seem careless with, for example, homework	☐	☐	☐	☐
2. Has difficulty keeping attention on what needs to be done	☐	☐	☐	☐
3. Does not seem to listen when spoken to directly	☐	☐	☐	☐
4. Does not follow through on instructions and does not finish activities (not because of refusal or lack of comprehension)	☐	☐	☐	☐
5. Has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	☐	☐	☐	☐
7. Loses things necessary for tasks or activities (eg, toys, assignments, pencils, books)	☐	☐	☐	☐
8. Is easily distracted by noises or other stimuli	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐

For Office Use Only
2s & 3s 0 /9

10. Fidgets with or taps hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat when remaining seated is expected	☐	☐	☐	☐
12. Runs about or climbs too much when remaining seated is expected	☐	☐	☐	☐
13. Has difficulty playing or beginning quiet play games	☐	☐	☐	☐
14. Is on the go or often acts as if "driven by a motor"	☐	☐	☐	☐
15. Talks too much	☐	☐	☐	☐
16. Blurts out answers before questions have been completed	☐	☐	☐	☐
17. Has difficulty waiting his or her turn	☐	☐	☐	☐
18. Interrupts or intrudes into others' conversations or activities or both	☐	☐	☐	☐

For Office Use Only
2s & 3s 0 /9

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1203410/adhdtk3e_s4_06_vanderbiltparentinformant.pdf
by Physician's Computer Company user

American Academy of Pediatrics

Vanderbilt Assessment Scale: *ADHD Toolkit* Parent-Informant Form

Child's name: _____ Today's date: _____

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)	
19. Loses temper	☐	☐	☐	☐	
20. Is touchy or easily annoyed	☐	☐	☐	☐	
21. Is angry or resentful	☐	☐	☐	☐	
22. Argues with authority figures or adults	☐	☐	☐	☐	
23. Actively defies or refuses to adhere to requests or rules	☐	☐	☐	☐	
24. Deliberately annoys people	☐	☐	☐	☐	
25. Blames others for his or her mistakes or misbehaviors	☐	☐	☐	☐	For Office Use Only
26. Is spiteful and wants to get even	☐	☐	☐	☐	2s & 3s 0 /8
27. Bullies, threatens, or intimidates others	☐	☐	☐	☐	
28. Starts physical fights	☐	☐	☐	☐	
29. Has used a weapon that can cause serious harm (eg, bat, knife, brick, gun)	☐	☐	☐	☐	
30. Has been physically cruel to people	☐	☐	☐	☐	
31. Has been physically cruel to animals	☐	☐	☐	☐	
32. Has stolen while confronting the person	☐	☐	☐	☐	
33. Has forced someone into sexual activity	☐	☐	☐	☐	
34. Has deliberately set fires to cause damage	☐	☐	☐	☐	
35. Deliberately destroys others' property	☐	☐	☐	☐	
36. Has broken into someone else's home, business, or car	☐	☐	☐	☐	
37. Lies to get out of trouble, to obtain goods or favors, or to avoid obligations (ie, cons others)	☐	☐	☐	☐	
38. Has stolen items of value	☐	☐	☐	☐	
39. Has stayed out at night without permission beginning before age 13	☐	☐	☐	☐	
40. Has run away from home twice or once for an extended period	☐	☐	☐	☐	For Office Use Only
41. Is often truant from school (skips school)	☐	☐	☐	☐	2s & 3s 0 /15
42. Is fearful, anxious, or worried	☐	☐	☐	☐	
43. Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐	
44. Feels worthless or inferior	☐	☐	☐	☐	
45. Blames self for problems or feels guilty	☐	☐	☐	☐	
46. Feels lonely, unwanted, or unloved; often says that no one loves him or her	☐	☐	☐	☐	
47. Is sad, unhappy, or depressed	☐	☐	☐	☐	For Office Use Only
48. Is self-conscious or easily embarrassed	☐	☐	☐	☐	2s & 3s 0 /7

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1203410/adhdtk3e_s4_06_vanderbiltparentinformant.pdf
by Physician's Computer Company user

Vanderbilt Assessment Scale: *ADHD Toolkit* Parent-Informant Form

Child's name: _____ Today's date: _____

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

For Office Use Only
4s 0 /8

For Office Use Only
5s 0 /8

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

Tic behaviors: To the best of your knowledge, please indicate if your 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, and 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, and 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 your child's activities (eg, reading, writing, walking, talking, eating)?
   ☐ No ☐ Yes

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1203410/adhdtk3e_s4_06_vanderbiltparentinformant.pdf
by Physician's Computer Company user

Vanderbilt Assessment Scale: *ADHD Toolkit* Parent-Informant Form

Child's name: _____ Today's date: _____

Previous diagnosis and treatment: Please answer the following questions to the best of your knowledge:

1. Has your child been diagnosed as having ADHD or ADD?
   ☐ No ☐ Yes
2. Is he or she on medication for ADHD or ADD?
   ☐ No ☐ Yes
3. Has your child been diagnosed as having a tic disorder or Tourette syndrome?
   ☐ No ☐ Yes
4. Is he or she on medication for a tic disorder or Tourette disorder?
   ☐ No ☐ Yes

Adapted from the Vanderbilt rating scales developed by Mark L. Wolraich, MD.

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: 0

Total number of questions scored 2 or 3 in questions 10–18: 0

Total number of questions scored 2 or 3 in questions 19–26: 0

Total number of questions scored 2 or 3 in questions 27–41: 0

Total number of questions scored 2 or 3 in questions 42–48: 0

Total number of questions scored 4 in questions 49–56: 0

Total number of questions scored 5 in questions 49–56: 0

The recommendations in this resource do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original resource included as part of *Caring for Children With ADHD: A Practical Resource Toolkit for Clinicians,* 3rd Edition.

Inclusion in this resource does not imply an endorsement by the American Academy of Pediatrics (AAP). The AAP is not responsible for the content of the resources mentioned in this resource. Website addresses are as current as possible but may change at any time.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this resource and in no event shall the AAP be liable for any such changes.

© 2020 American Academy of Pediatrics. All rights reserved.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1203410/adhdtk3e_s4_06_vanderbiltparentinformant.pdf
by Physician's Computer Company user

Child ID#: _____ Child age _____

Caregiver: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS*:* Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

	Please mark under the heading that best fits your child			***For Office Use***		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad.	☐	☐	☐			
2. Feel hopeless.	☐	☐	☐			
3. Feel down on him/herself.	☐	☐	☐			
4. Worry a lot.	☐	☐	☐			
5. Seem to be having less fun.	☐	☐	☐			
6. Fidget, is unable to sit still.	☐	☐	☐			
7. Daydream too much.	☐	☐	☐			
8. Distract easily.	☐	☐	☐			
9. Have trouble concentrating.	☐	☐	☐			
10. Act as if driven by a motor.	☐	☐	☐			
11. Fight with other children.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him her.	☐	☐	☐			
TOTAL						

To Score:

Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

Positive Scores:

PSC17-I	≥ 5
PSC17-A	≥ 7
PSC17-E	≥ 7
Total Score	≥ 15

Lafayette
Pediatric Clinic

Tanya Fitts, M.D.
BOARD CERTIFIED IN PEDIATRICS
Donica Long, FNP-C

Dear Educator:

The parent(s) of the above child have requested an evaluation by our office for a health concern. As part of the evaluation process, we ask that both the child's parent(s) and teacher(s) complete a set of behavioral rating scales. Enclosed please find a set of teacher rating scales and questionnaires for your attention. These forms include: (1) Teacher Questionnaire (2) NICHQ Vanderbilt Teacher Assessment Scale.

Generally, the teacher who spends the most time with the child should complete these forms. However, if the child has more than on primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of forms from each teacher. If this is the case, please feel welcome to make the necessary copies.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write "Don't know," so that we can be sure the item was not overlooked. After the forms are completed, please fax them to our office at (662) 236-3924. Thank you for your assistance and cooperation in the completion of these forms. If you have any questions, please do not hesitate to contact our office at (662) 236-3939.

Sincerely,

Lafayette Pediatric Clinic

1300 Access Road, Ste. 400 Oxford, MS 38655 | tel: 662.236.3939 fax: 662.236.3924
LAFAYETTEPEDIATRICS.NET

Lafayette
Pediatric Clinic

Tanya Fitts, M.D.
BOARD CERTIFIED IN PEDIATRICS
Donica Long, FNP-C

ADHD Initial Teacher Questionnaire

Child's Name School Name _____ Date Completed _____

School Name _____ Child's Grade_____

Teacher's Name_____ Subject Taught _____

Hours with child (daily average) _____ Number of Students in Class_____

1.How long have you known this child?_____

2. Please rate this child's academic success compared to other children the same age:

____Much Worse ____Worse ____About the Same ____Better ____Much Better

3. Please rate this child's behavior compared to other children the same age:

____Much Worse ____Worse ____ About the Same ____Better ____Much Better

4. Number of school days absent/tardy:_____

5. Record the results of any IQ or other educational test this student has taken: _____

_____

6. Please list consultations previously obtained from psychologists, neurologists, speech therapists, etc., or school staff:

_____

7. Please list or describe any special help or services this child is receiving inside/outside your class: _____

_____

_____

_____

_____

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.

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

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

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ
National Initiative for Children's Healthcare Quality

McNeil
Consumer & Specialty Pharmaceuticals