

ADHD Initial Evaluation Packet

Information for Parents

Additional Resources

Parent Packet

- **Patient Medical History and Symptom Questionnaire**
- **Family, Home and School History**
- **Home NICHQ Forms (2 pages)**

Teacher / School Packet

- **Letter to Teachers**
- **School Information Questionnaire**
- **School Information Release**
- **School NICHQ Forms (2 pages)**

ADHD: Parents Medication Guide

Melanie Wick, MD 2018

Information for Parents

Attention deficit hyperactivity disorder (ADHD) is a common behavior problem. Studies estimate that between four and twenty percent of American children have ADHD.

There are many symptoms of ADHD, they include: restlessness, difficulty paying attention, impulsivity, making noise, fidgeting, talking too much, difficulty completing tasks, disorganized behavior, and others. These problems lead to difficulty at school and at home. Each child may not have all the above symptoms but some combination of these is present in every child with ADHD.

The cause of ADHD is not known. Studies have shown that can "run in families", but an exact reason for has not been determined. All children mature at different rates. It may help to think that ADHD occurs when the part of the brain that controls impulses and attention matures a little too slowly. This becomes a problem when other children at school can pay better attention leaving children with ADHD behind. Many children with ADHD "grow out of it", learning to control their impulses and pay attention as they grow older.

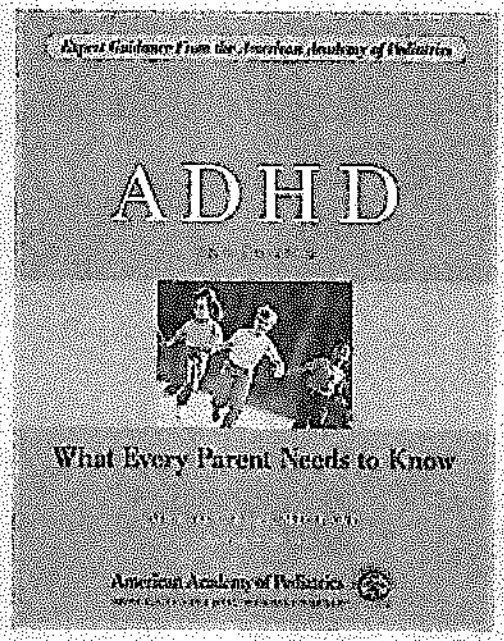
ADHD is not a learning disability, "mental disorder", or emotional problem. This is often confusing because symptoms of ADHD can be similar to these other problems. Also, some children may have both ADHD and one of these other problems. For these reasons it is very important to completely evaluate each child before making the diagnosis of ADHD. Information from school about grades, attendance, IQ, and interaction with others is needed. It is also important to talk to parents and find out how these problems affect the child at home.

Once the diagnosis is made treatment for ADHD can be started. A successful treatment program begins with awareness of the problem and modifications of the home and school environments. Providing shorter work periods at school with more frequent breaks and a quiet place to work can help the child focus his attention. These changes can also help with doing homework and other work at home. Individual and family therapy may also help certain patients who have problems with self-esteem, depression, or anxiety about ADHD. Many children also benefit from medication. Medications that are effective in the treatment of ADHD include stimulants (methylphenidate and dexadrine), nonstimulants (atomoxetine), and antidepressants (imipramine and desipramine). Methylphenidate is the most commonly used medication and comes in many brand name forms. These medications increase the chemicals normally found in the brain which help to inhibit or decrease the problem behaviors. Side effects with these medications are usually minor (headache, stomach ache, appetite changes) and usually go away after the child takes the medication for a few weeks.

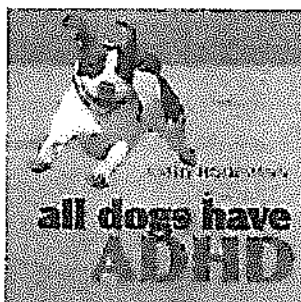
Discuss your child's specific behavior problems and your concerns with your child's doctor. Together you can decide on the best approach and treatment plan for your child's specific needs.

Melanie Wick, MD (2014)

I recommend the book ADHD: What Every Parent Needs to Know by Michael I. Reiff, to help families learn more about ADHD and treatment options.



When discussing ADHD with your child the book All Dogs Have ADHD by Kathy Hoopmann provides descriptions of ADHD that children can understand.



I have included a copy of the ADHD Parents Medication Guide, at the end of this packet, to provide information about medication if that is appropriate for your child. This information for parents was developed by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, and can also be found online at parentsmedguide.org.

Melanie Wick, MD 2104

Parent Packet

**Please Complete the Forms in this Packet
and Return them to your child's Pediatrician**

PATIENT MEDICAL HISTORY AND SYMPTOM QUESTIONNAIRE

Child's Name:	DOB:
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Questionnaires were completed by:

Relationship to child:
At the time that these forms are completed:

	My child does <i>not</i> take any medication for behavior problems. My answers are based on my child's behavior while he/she is off medication.
	My child is <i>currently taking medication</i> for behavior problems. However, my answers are based on my child's behavior while he/she is <i>OFF</i> medication.
	My child is <i>currently taking medication</i> for behavior problems. My answers are based on my child's behavior while he/she is <i>ON</i> medication.

Behavior concerns have been present for:

weeks	months	years	lifelong
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Concerns today include (check all that apply):

behavior problems at home	inattention and distractibility
behavior problems at school	school failure
hyperactivity	school related problems
impulsivity	Other issues

Symptoms have included:

increased motor activity	inattention	low self-esteem
aggressive behavior	low self-confidence	school difficulties
dependence on supervision	frequent task redirection	trouble with relationships
disruptive behavior	unusual risk taking	Other concerns...
impulsivity	academic underachievement	
inability to follow directions	behavioral problems	

Please place a check by any additional medical concerns that have been present:

anxiety disorder	cognitive impairment	mood disorder
bathroom issues	depression	oppositional defiant behavior
bed wetting	memory disorder	psychiatric disease
Speech delay	Other:	

What would you like to like to change most about your child's behavior?

What are some of your child's best qualities?

Please list other doctors or specialists that your child has seen for behavior or attention problems:

Family, Home, and School History		
Child's School:		Grade:
Mom's Name:		DOB:
Dad's Name:		DOB:
Other Caregivers:		
Child lives with:		
Is child adopted? Yes No If yes, age when adopted		
Who lives at home?		
Are parents married? Yes No	Separated? Yes No	Divorced? Yes No
Are there smokers at home? Yes No		
Type of home? (house/apartment)		
Any history of lead exposure? Yes No		
Has your child ever been held back in school? Yes No		
Does anyone in the family have:		
Attention problems?	Who?	
Depression / Anxiety		
Other Psychiatric Illnesses		
Developmental and Age Appropriate Activities		
Does the patient...		
usually have good behavior?	Yes	No
read at grade level?	Yes	No
engage in hobbies?	Yes	No
show positive interaction with adults?	Yes	No
acknowledge limits and consequences?	Yes	No
handle anger well?	Yes	No
perform well with conflict resolution?	Yes	No
participate in chores?	Yes	No
Has the patient been diagnosed with...		
ADHD		
autism/communication disorder		
cerebral palsy		
cognitive impairment		
developmental disabilities		
language delay		
learning disability		
other		

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.

Revised - 1102

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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:

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: _____



Teacher Packet

**Please send the Forms in this Packet to
School to have your child's teacher
Complete and then Return them to your
child's Pediatrician**

Student:

DOB:

Teacher:

Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires. These forms include:

- 1. Release of Information Form – if needed for your school**
- 2. School Information Form**
- 3. NICHQ Vanderbilt Teacher Assessment Scale**

Generally, the teacher who spends the most time with the child should complete the teacher rating scales.

However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact us directly at 903-595-3942 and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

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 simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. The forms should be mailed to us directly in the envelope provided.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,
Melanie Wick, MD
Trinity Pediatric Clinic
706 Turtle Creek Drive
Tyler, Texas 75701
903-595-3943
Fax 903-606-1210

Authorization for the Release of Information

I, the undersigned, hereby request:

Immunization Records / Medical Records From:

Doctor's Office or School Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

to release information from the Medical Records of:

Patient's Name: _____

DOB: _____

Please send Records to:

**Trinity Pediatric Clinic
706 Turtle Creek Drive
Tyler, Texas 75701
903-595-3942
Fax 903-606-1210**

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. This authorization will expire sixty (60) days from the date of my signature unless otherwise specified.

Date: _____ **Signature:** _____

(parent or legal representative)

(relationship to patient)

School Information For:		
DOB:		
School:	Grade Level:	
Best person to contact at school about this student:		
If yes, please provide additional information.		
Has this been identified by school personnel as having problems with impulsivity, increased motor activity and classroom disruption?	No	Yes
Is this student in any special education programs?	No	Yes
Has this student had IQ testing or learning disability tests? (please send copies of evaluations)	No	Yes
Has this student been evaluated for ADHD before?	No	Yes
Has this student been evaluated for any psychiatric or physical illnesses?	No	Yes
Has physical or other abuse ever been suspected in this student?	No	Yes
Does this interact well with other students?	No	Yes
Does this student interact well with teachers?	No	Yes
Attendance: How many days of school has this student missed	Results of most recent Vision Test	Results of most recent hearing test:
This Year: _____	Right Eye /20	<input type="checkbox"/> Normal
Last Year: _____	Left Eye /20	<input type="checkbox"/> Abnormal (send results)
		<input type="checkbox"/> Not done
Please give examples of the student's problems in school.		

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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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		Somewhat of a Problem			
Academic Performance		Excellent	Above Average	Average	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		Somewhat of a Problem			
		Excellent	Above Average	Average	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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