Vanderbilt Parent Assessment Follow-Up **Page 1**

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

Each rating should be considered in the context of what is appropriate for the age of your child.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication

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 misunderstanding)	0	1	2	3	
5. Has difficulty organizing task and activities	0	1	2	3	
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental efforts	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	Count # 2s + 3s
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/her turn	0	1	2	3	Count # 2s + 3s
18. Interrupts or intrudes in others' conversations and/or activities	0	1	2	3	TSS 1-18

IMPAIRMENT	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
A. Overall School Performance	1	2	3	4	5	
B. Reading	1	2	3	4	5	
C. Writing	1	2	3	4	5	
D. Mathematics	1	2	3	4	5	
E. Relationship with parents	1	2	3	4	5	
F. Relationship with siblings	1	2	3	4	5	
G. Relationship with peers	1	2	3	4	5	Count # 4s + 5s
H. Participation in organized activities (e.g., teams)	1	2	3	4	5	APS 19-26

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

FAX OR MAIL COMPLETED FORM TO: (Check one office/location)

	(Enter practice contact information) Name of Practice Street Address Phone Number/Fax Number		(Enter practice contact information – 2nd office/location) Name of Practice Street Address Phone Number/Fax Number
	(Enter practice contact information – 3rd office/location)		(Enter practice contact information – 4th office/location)

-Please Turn Over-

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

Side-Effects Rating Scale

Instructions: Listed below are several possible negative effects (side effects) that medication may have on an ADHD child. Please read each item carefully and use the boxes to rate the severity of your child's side effects he/she has been on his/her current dose of medication. When requested, or wherever you feel it would be useful for us to know, please describe the side effects that you observed or any other unusual behavior in the "Comments" section below.

Use the following to assess severity:

None: The symptom is not present.

Mild: The symptom is present but is not significant enough to cause concern to your child, to you, or to his/her friends. Presence of the symptom at this level would NOT be a reason to stop taking the medicine.

Moderate: The symptom causes impairment of functioning or social embarrassment to such a degree that the negative impact on social and school performance should be weighed carefully to justify benefit of continuing medication must be considered.

Severe: The symptom causes impairment of functioning or social embarrassment to such a degree that the child should not continue to receive this medication or dose of medication as part of current treatment.

	None	Mild	Moderate	Severe
Motor Tics–repetitive movements: jerking or twitching (e.g., eye blinking–eye opening, facial or mouth twitching, shoulder or arm movements)–describe below				
Buccal–lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting– describe below				
Picking at skin or fingers, nail biting, lip or cheek chewing – describe below				
Worried/Anxious				
Dull, tired, listless				
Headaches				
Stomachache				
Crabby, Irritable				
Tearful, Sad, Depressed				
Socially withdrawn – decreased interaction with others				
Hallucinations (see or hear things that aren't there)				
Loss of appetite				
Trouble sleeping (time went to sleep)				

Adapted from the Pittsburgh Side-Effects Rating Scale

COMMENTS: