NICHQ Vanderbilt Assessment* -- Follow-up
PARENT Informant

Today's Date:_____
Child's Name:_____
Date of Birth:_____
Parent's Name:_____
Telephone Number:_____

Please Return this form to:
Provider:_____
Children's Medical Group
500 Greene Street Cumberland, MD 21502
Fax: (301) 724-4811

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

Symptoms		**Never**	**Occaionally**	**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

*Adapted from The Assessment Scales of the National Initiative for Children's Healthcare Quality

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Child's Name:_____

Side Effects: Are these side effects currently a problem?

Has the child experienced any of the following side effects or problems in the past month?	None	Mild	Moderate	Severe
Headache				
Stomachache				
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: _____

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