

**NICHQ Vanderbilt Assessment* -- Follow-up
TEACHER Informant**

Today's Date: _____
 Child's Name: _____ DOB: _____
 Class Name/Period: _____ Time: _____
 Teacher's Name: _____
 School Name: _____ Grade Level: _____

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

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 paying 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

		Excellent	Above Average	Average	Somewhat of a problem	Problematic
19. Reading		1	2	3	4	5
20. Mathematics		1	2	3	4	5
21. Written expression		1	2	3	4	5
22. Relationship with peers		1	2	3	4	5
23. Following direction		1	2	3	4	5
24. Disrupting class		1	2	3	4	5
25. Assignment completion		1	2	3	4	5
26. Organizational skills		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Socially withdrawn - decreased interaction with others				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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