NICHQ Vanderbilt Assessment Follow-up: Parent Informant

Today's Date: _____

Child's Name: _____

Child's 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. Please think about your child's behaviors since the last assessment scale was filled out when rating his or her behaviors. Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

If on medication, please list medication name and dose: _____

Symptoms	Never	Occasionally	Often	Very Often	
1. Does not pay attention to details or makes careless mistakes with, for example, homework	○	○	○	○	
2. Has difficulty keeping attention to what needs to be done	○	○	○	○	
3. Does not seem to listen when spoken to directly	○	○	○	○	
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	○	○	○	○	
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 (toys, assignments, pencils, books)	○	○	○	○	
8. Is easily distracted by noises or other stimuli	○	○	○	○	
9. Is forgetful in daily activities	○	○	○	○	For Office Use Only 2 & 3s: 0 /9
10. Fidgets with 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 activities	○	○	○	○	
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 in on others' conversations and/or activities	○	○	○	○	For Office Use Only 2 & 3s: 0 /9

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults	○	○	○	○	
20. Loses temper	○	○	○	○	
21. Actively defies or refuses to go along with adults' requests or rules	○	○	○	○	
22. Deliberately annoys people	○	○	○	○	
23. Blames others for his or her mistakes or misbehaviors	○	○	○	○	
24. Is touchy or easily annoyed by others	○	○	○	○	
25. Is angry or resentful	○	○	○	○	
26. Is spiteful and wants to get even	○	○	○	○	For Office Use Only 2 & 3s: 0 /8

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
27. Reading	○	○	○	○	○	
28. Writing	○	○	○	○	○	For Office Use Only 4s: 0 /3
29. Mathematics	○	○	○	○	○	For Office Use Only 5s: 0 /3
30. Relationship with parents	○	○	○	○	○	
31. Relationship with siblings	○	○	○	○	○	
32. Relationship with peers	○	○	○	○	○	For Office Use Only 4s: 0 /4
33. Participation in organized activities (eg, teams)	○	○	○	○	○	For Office Use Only 5s: 0 /4

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

Side Effects: Has your child experienced any of the following side effect or problems in the past week?	Are these side effects currently a problem? None	Mild	Moderate	Severe
Headache	○	○	○	○
Stomachache	○	○	○	○
Change of appetite—explain below	○	○	○	○
Trouble sleeping	○	○	○	○
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 check chewing—explain below	○	○	○	○
Sees or hears things that aren't there	○	○	○	○

Explain/Comments:

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD. Available for downloading at no cost in expanded format at http://ccf.FIU.edu.

PATIENT HEALTH QUESTIONNAIRE

PHQ-9 - Nine Symptom Checklist

Patient Name:_____ Date:_____

Date of Birth: _____ PCP: _____

Member ID# _____

1. Over the *last two weeks* how often have you been bothered by any of the following problems?

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
	0	1	2	3
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling/staying asleep, sleeping too much	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i. Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

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2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely Difficult
❑	❑	❑	❑

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

❑ Yes ❑ No

Total# Symptoms:_____ Total Score:_____