AHWATUKEE PEDIATRICS, PC

Parent Interview

Parents Name(s) _____ Today's Date: _____

Child's Name _____

Child's Age: _____ Child's Grade: _____

Referral Source: _____

Present Problem:

Current Behavior Concerns:

Primary Concerns:

Other Related Concerns:

Temperament and personality characteristics:

Past Medical History:

Pregnancy Normal _____ Problems _____

Birth / Vaginal / C-Section Normal _____ Problems _____

Developmental History: Normal _____ Delays ____

If delays, what are/were they:

First Year Behavioral History:

Medical / Health History:

Family Medical History:

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Siblings:

Current Medications:

Prior ADHD Diagnosis and/or History:

Stressors:

Mother's Psychiatric History:
Father's Psychiatric History:
Other Psychiatric History:

Social History:
- Lives at home with Mother / Father / Siblings (how many)
- Parents are divorced / separated
- Describe living arrangements

School performance/problems:
- Distractibility:
- Impulsivity:
- Inattention:
- Motor activity levels:

Check all areas of concern:		**Circle Yes or No Below**
Fidgets	_____	Seen in most all situations? Yes / No
Difficulty remaining seated	_____	Seen in most all situations? Yes / No
Easily distracted	_____	Seen in most all situations? Yes / No
Often blurts out answers to questions before they have been completed	_____	Seen in most all situations? Yes / No
Difficulty following instructions	_____	Seen in most all situations? Yes / No
Difficulty sustaining attention	_____	Seen in most all situations? Yes / No
Shifts from one activity to another	_____	Seen in most all situations? Yes / No
Difficulty playing/sitting quietly	_____	Seen in most all situations? Yes / No
Often talks excessively	_____	Seen in most all situations? Yes / No
Often interrupts or intrudes on others	_____	Seen in most all situations? Yes / No
Often does not listen	_____	Seen in most all situations? Yes / No
Often loses things	_____	Seen in most all situations? Yes / No
Often engages in physically Dangerous activities	_____	Seen in most all situations? Yes / No

Age of onset for these concerns? _____

What form of discipline have you attempted?

Does the child have any appetite control problems?
Overeats _____ Average _____ Under eats _____

Has the child ever been prescribed any of the following?

Adderall	____	Duration of Use _____	Most recent dosage _____
Concerta	____	Duration of Use _____	Most recent dosage _____
Kapvay	____	Duration of Use _____	Most recent dosage _____
Intuiv	____	Duration of Use _____	Most recent dosage _____
Resperdal	____	Duration of Use _____	Most recent dosage _____
Ritalin	____	Duration of Use _____	Most recent dosage _____
Strattera	____	Duration of Use _____	Most recent dosage _____
Vyvance	____	Duration of Use _____	Most recent dosage _____
Other	_____	Duration of Use _____	Most recent dosage _____

Has the child ever had any of the following forms of psychological treatment?

Individual psychotherapy	Yes / No	Duration of Therapy _____
Group psychotherapy	Yes / No	Duration of Therapy _____
Family therapy with child	Yes / No	Duration of Therapy _____
Inpatient evaluation/Rx	Yes / No	Duration of Therapy _____
Residential treatment	Yes / No	Duration of Therapy _____

School History:
Please summarize the child's progress (e.g., academic, social, testing) within each of these grade levels):

Preschool:

Kindergarten:

Grades 1 thru 3:

Grades 4 thru 6:

Grades 7 thru 12:

Has the child even been in any type of special educational program, and if so, how long?

Leaning disabilities class	Yes / No	Duration of Placement _____
Behavioral/emotional disorders class	Yes / No	Duration of Placement _____
Resource room	Yes / No	Duration of Placement _____
Speech & language therapy	Yes / No	Duration of Placement _____
Other (please specify)	Yes / No	Duration of Placement _____

Has the child ever been:

Suspended from school	Yes / No	Number of suspensions	_____
Expelled from school	Yes / No	Number of expulsions	_____
Retained in grade	Yes / No	Number of retentions	_____

Have any additional instructional modifications been attempted?

None	_____		
Behavior modification programs	Yes / No		
Daily/weekly report card	Yes / No		
Counseling	Yes / No	How often _____	When _____
Tutoring	Yes / No	How often _____	When _____
Other (please specify)	_____		

How does the child get along with siblings?

How easily does the child make friends?

On average, how long does your child keep friendships?

What strategies have been implemented to address these problems?

Verbal reprimands	_____	Physical punishment	_____
Time out (isolation)	_____	Avoidance of child	_____
Removal of privileges	_____	Acquiescence/giving in to child	_____
Rewards	_____	Other	_____

To what extent are you and your spouse ***consistent*** with respect to disciplinary strategies?

Most of the time	_____
Some of the time	_____
None of the time	_____

Have any of the following stress events occurred within the past 12 months?

Parents divorced or separated	Yes / No	Family accident or illness	Yes / No
Death in family	Yes / No	Parent changed job	Yes / No
Changed schools	Yes / No	Family moved	Yes / No
Family financial problems	Yes / No	Other (specify)	Yes / No

D5 **NICHQ Vanderbilt Assessment Follow-up—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. Please think about your child's behaviors in the past _____ when rating his/her 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. 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 Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects 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 cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

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Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

Other Concerns

Has the child exhibited any of the symptoms below?

Stereotyped mannerisms	Yes / No
Odd posture	Yes / No
Excessive reaction to noise or fails to react to loud noises	Yes / No
Overreacts to touch	Yes / No
Compulsive rituals	Yes / No
Motor tics	Yes / No
Vocal tics	Yes / No

Has the child exhibited any of the symptoms of thoughts disturbance, including any of the following?

Loose thinking (e.g., tangential ideas, circumstantial speech)	Yes / No
Bizarre idea (e.g., odd fascinations, delusions, hallucinations)	Yes / No
Disoriented, confused, staring, or 'spacey'	Yes / No
Incoherent speech (mumbles, jargon)	Yes / No

Has the child exhibited any symptoms of mood disturbance, including any of the following?

Excessive change in moods without reference to environment	Yes / No
Explosive temper with minimal provocation	Yes / No
Excessive clinging, attachment, or dependence on adults	Yes / No
Unusual fears	Yes / No
Strange aversions	Yes / No
Panic attacks	Yes / No
Excessively constricted or bland affect	Yes / No
Situational inappropriate emotions	Yes / No

Has the child exhibited any symptoms of social conduct disturbance, including any of the following?

Little or no interest in peers	Yes / No
Significantly indiscreet remarks	Yes / No
Initiates or terminate interactions inappropriately	Yes / No
Qualitatively abnormal social behavior	Yes / No
Excessive reaction to changes in routine	Yes / No
Abnormalities of speech	Yes / No
Self-mutilation	Yes / No

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

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. 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. 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 Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has your child experienced any of the following side effects 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 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: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

Side Effects Questionnaire
Parent Interview

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

Parent's Name(s): _____ Parent's Phone: _____

Name of Current **Medication** and **Dosage** child is taking: _____

Child's Date of Birth: _____

Has your child experienced any of the following side effects or problems in the past week?

None – 0 **Mild – 1** **Moderate – 2** **Severe - 3**
Circle below

Headache	0	1	2	3
Stomachache	0	1	2	3
Change of appetite – explain below	0	1	2	3
Trouble sleeping	0	1	2	3
Irritability in the late morning, late afternoon, or Evening – explain below	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, Eye blinking – explain below	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek Chewing – explain below	0	1	2	3
Sees or hears things that aren't there	0	1	2	3

Any concerns at all, regarding depression or suicidal thoughts or tendencies? Yes / No
Explanations / Comments: