

Parent Questionnaire for New Patients

Hello,

Thank you for contacting Developmental & Behavioral Pediatrics. The attached questionnaire gives you a chance to tell us about your child. Knowing about things like your child's health, past experiences, and family history can help us help your child.

If you have questions about this form or have difficulty filling it out, please call our office at (585) 275-2986.

We also need the following:

- Most Recent School Testing
- Current IEP or 504 Plan

These forms are needed before we can place your child on our wait list.

Once you have completed this form, please send it to:

Intake Coordinator
Developmental Behavioral Peds

601 Elmwood Avenue, Box 278877
Rochester, NY 14642

Fax: (585) 742-4217
DBPintake@URMC.rochester.edu



Child's name _____

Child's date of birth _____

Child's address _____

Date form completed _____

Child's medical insurance company _____

Policy Number _____

Persons Completing Form

Name	Relationship to child	Does the child live with you?	Phone numbers
	<input type="checkbox"/> Biologic parent <input type="checkbox"/> Foster/adoptive parent <input type="checkbox"/> Relative <input type="checkbox"/> Guardian <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	(H) (C) (W)
	<input type="checkbox"/> Biologic parent <input type="checkbox"/> Foster/adoptive parent <input type="checkbox"/> Relative <input type="checkbox"/> Guardian <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	(H) (C) (W)

Home Information

Main language spoken at home English Spanish American sign language Other:

Please list all adults and children who live at home with this child.

Name	Age	Relationship to child	Occupation or grade in school	Has this person ever been seen in Kirch/DBP?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

What is the reason you would like your child seen in this program? What questions do you have?

Has your child ever been diagnosed by a doctor or psychologist with a developmental or behavioral disorder?
 Yes No Autism ADHD Cerebral palsy Anxiety disorder
 Who made the diagnosis and when? Down syndrome Other:

Has anyone (teacher, pediatrician, friend, relative) suggested your child be evaluated for a specific diagnosis?
 Yes No
 What diagnosis?

Child Strengths

Tell us about the child's **strengths**. What is your child good at? What are his or her interests? What things are going well?

Parent/Guardian Concerns

What concerns do you have about your child right now?

Concern	
Large motor skills (sitting, walking, running, moving around)	<input type="checkbox"/>
Small motor skills (using hands and fingers, writing, using utensils)	<input type="checkbox"/>
Communication (using words/gestures/signs; expressing wants/needs, understanding others)	<input type="checkbox"/>
Thinking, learning, and memory	<input type="checkbox"/>
Social skills (making friends, playing with others, showing interest in others)	<input type="checkbox"/>
Play skills (using toys, pretend playing)	<input type="checkbox"/>
Self-care (feeding himself/herself, getting dressed/undressed, helping around the house)	<input type="checkbox"/>
Short attention span	<input type="checkbox"/>
Hyperactivity (constantly moving, restless, active)	<input type="checkbox"/>
Anxiety (worrying, shy, fearful, problems separating from parents)	<input type="checkbox"/>
Repetitive thoughts/behavior (does things over and over, gets "stuck")	<input type="checkbox"/>
Repetitive motor mannerisms (rocks, flaps hands, walks on toes, paces)	<input type="checkbox"/>
Mood swings/irritability (unpredictable changes between emotions)	<input type="checkbox"/>
Tantrums	<input type="checkbox"/>
Aggression (hits or bites others)	<input type="checkbox"/>
Self-injury (bangs head, hits self, bites self)	<input type="checkbox"/>
Sensory issues (over/under-sensitive to sounds, touch, smell)	<input type="checkbox"/>
Sleep problems (trouble falling asleep, wakes frequently, still sleeps with adult)	<input type="checkbox"/>
Safety problems (runs away, escapes from house, poor awareness of danger, climbs to high spots)	<input type="checkbox"/>
Other behavior concerns	<input type="checkbox"/>

Please make notes about any concerns selected above.

Health History

Are any of the following health concerns a problem for the child currently or were a past concern?

Concern	Never	Currently	In the past
Genetic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury/brain problem (hydrocephalus, brain bleed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics, tremors, or unusual movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear or hearing problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental or tooth problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart rhythm problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing/lung problem, asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI problem: vomiting/reflux/stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea (loose, watery stools)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation (hard, painful stools)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding problem or use of a feeding tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting things in mouth that are not food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/bladder/genital problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone, joint, or muscle problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine or hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health concern not listed above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected any of the boxes above, please describe...

Does your child use any adaptive equipment?

Glasses Hearing aids Walker Wheelchair Communication device Other:

What medicines, vitamins, and nutrition supplements does your child take each day?

Medicine name or vitamin/supplement name and brand	Dose (how many mg and how often)	Reason and who writes prescriptions

Has your child taken medicines to treat chronic health or behavior problems *in the past*?

Medicine name	Dose (how many mg and how often)	Reason

Does your child eat a special diet or have any food restriction? Please describe.

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Has your child ever been admitted to the hospital overnight or had surgery?

Age	Reason

Has your child had blood drawn to test lead level?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If "Yes", was the lead level high?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Is your child up to date on immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Has your child had a hearing test?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If "Yes", at what age?	

Pregnancy and Birth History

The following questions are about the pregnancy *with the child being evaluated*.

How many times has the mother been pregnant?	
How many children does the birth mother have?	
How many of those children are older than this child?	

Did the birth mother...

Lose any pregnancies (have a miscarriage)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Terminate any pregnancies due to a health problem/genetic condition of the baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Need treatment to become pregnant (fertility medicine, intrauterine insemination, IVF)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Receive prenatal care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Have any infections or fevers during the pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Have high blood pressure during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Have diabetes during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Have any other complications during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If "Yes", please describe:

What vitamins and medicines did the biological mother take during pregnancy?

Choose the one that best describes alcohol use *during* pregnancy...

- Unsure if mother used or not Mother used, but unsure of amount No use 1 drink or less per week
 1 drink per day 2 or more drinks per day

** If unsure, it is very helpful to the evaluation to try to obtain birth records or talk to the birth mother or those who knew her during pregnancy to find out more information. **

During which trimesters did the mother drink alcohol?	<input type="checkbox"/> None <input type="checkbox"/> Unsure <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd
What other substances were taken during pregnancy?	<input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Pain Killers <input type="checkbox"/> Meth <input type="checkbox"/> Other:

Labor and Delivery

Birth mother's age at birth of child _____ Birth father's age at birth of child _____ Birth weight _____
 Birth length _____ Birth head circumference _____

Was this child...	<input type="checkbox"/> Single birth <input type="checkbox"/> One of twins <input type="checkbox"/> One of triplets <input type="checkbox"/> Other multiple
Was this child born by...	<input type="checkbox"/> Vaginal delivery <input type="checkbox"/> Cesarean section
Were there any labor/delivery complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please describe:
Was the baby born early?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If "Yes", weeks early:
Was your child admitted to the Special Care Nursery or NICU (neonatal ICU)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If "Yes", please describe:
When discharged from the hospital, who did your child go home with?	<input type="checkbox"/> Biologic mother/parents <input type="checkbox"/> Grandparents <input type="checkbox"/> Other relative <input type="checkbox"/> Foster parent <input type="checkbox"/> Other

Developmental History

Please describe any concerns about your child's development between birth and age 3.

Please describe if your child has ever lost skills he/she once had (i.e., learned words then stopped talking).

Is your child...	Yes	No	Age learned
Walking without holding on?	<input type="checkbox"/>	<input type="checkbox"/>	
Using single words?	<input type="checkbox"/>	<input type="checkbox"/>	
Using phrases to talk?	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet trained?	<input type="checkbox"/>	<input type="checkbox"/>	

Child Experiences and Social History

Has your child experienced any of the following?

Serious illness, surgery, or hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Serious illness, surgery, or hospitalization of a close family member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Death of someone close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
House fire, flood, storm, or other disaster?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Divorce of parents or caregivers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Alcohol or drug abuse by a family member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Seeing parents hitting/hurting each other?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Mental illness in a family member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Seeing violence in the community (robbery, shooting, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Neglect (adult caregiver not giving the child the care he/she needs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Physical abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Sexual abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Placement in foster care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Change in primary caregiver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

For children in the care of a relative, adoptive or foster parent, or someone who is NOT the biologic parent...

How long has this child been in your care?

Describe the circumstances that led to you caring for this child.

If this child has been in the care of others who are not the biologic parents, please indicate when and who.

Family History

Please indicate if someone in the child's biologic family has any of the following disorders.

ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Autism spectrum disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Blindness or visual impairment in childhood	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Bipolar disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Celiac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Deafness present at birth or in childhood	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Heart rhythm problems, pacemaker, defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Heart attack at young age (under age 40)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Intellectual disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Learning disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Migraine headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Miscarriages or loss of more than one pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Speech delay or disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Sudden death	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Sudden infant death syndrome (SIDS), other death in infancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>

Tremor or other problem with moving muscles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Other conditions not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Relative on mother's side <input type="checkbox"/> Relative on father's side <i>Relationship:</i>
Please describe...		

Current Education/School

Home school district	
School name	
Does the child have any of the following supports?	<input type="checkbox"/> AIS <input type="checkbox"/> 504 plan <input type="checkbox"/> IEP <input type="checkbox"/> FBA <input type="checkbox"/> BIP <input type="checkbox"/> EI <input type="checkbox"/> IFSP <input type="checkbox"/> District-based services <input type="checkbox"/> Unsure
Please select the educational services your child receives.	<input type="checkbox"/> Speech therapy <input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Special education teacher <input type="checkbox"/> Small classroom <input type="checkbox"/> DIR/floortime <input type="checkbox"/> Vision therapy/services <input type="checkbox"/> Social skills training <input type="checkbox"/> ABA <input type="checkbox"/> Counseling <input type="checkbox"/> Learning center/resource room <input type="checkbox"/> Other:

Home and Community Supports	Name/address	Phone number
Individual therapy/behavior intervention/counseling <i>(A treatment summary from the child's therapist is VERY important to our evaluation; please include with the information you send us!)</i>		
OPWDD services/SPOA services/Bridges to Health		
Psychiatrist <i>(A treatment summary from the child's psychiatrist is VERY important to our evaluation; please include with the information you send us!)</i>		
Please list any clubs, activities, or sports your child is involved with.		

Consent for Evaluation

I request that my child (named above) be evaluated by Developmental and Behavioral Pediatrics at Golisano Children's Hospital. I understand that Developmental and Behavioral Pediatrics is a training facility and that trainees supervised by faculty may be utilized to administer some evaluations.

If there is joint custody, signatures are required from both parents.

Parent/Caregiver Signature

Date

Parent/Caregiver Signature

Date

Please complete and fax or mail to:
Developmental and Behavioral Pediatrics, 601 Elmwood Ave, Box 278877, Rochester, NY 14642
Fax: (585) 742-4217

Provider: ___ Cole ___ Hems ___ Kroening ___ Kraus ___ Swantz ___ Patanella ___ Reiffer ___ Ryan ___ Smith ___ Stump ___ Sulkes
 ___ Verwey ___ Kirby ___ Knight ___ Kuo ___ Nguyen ___ Palicki

NICHQ Vanderbilt Assessment Scale—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.
 When completing this form, please think about your child's behaviors in the past 6 months.

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
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Symptoms (continued)	Never	Occasionally	Often	Very Often
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

