ROSS E. WILLIAMS, M.D., F.A.A.P.

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

1121 MEDICAL CENTER DRIVE - WILMINGTON, NORTH CAROLINA 28401
PHONE: 910.763.8134 FAX: 910.763.3311

ADHD and Behavioral Evaluations

Suggestions for completing questionnaires:

1. There are three or four questionnaires. These are very important. We need **all** of these at the time of your initial evaluation appointment.

2. The Pediatric Health History Questionnaire is for the parent or guardian to complete. The Adolescent Health History Questionnaire (for those ages 13 and up) is for the adolescent to complete with the help of his/her parent or guardian.

3. The ASQ-3 and ASQ-SE parent questionnaires are for those under the age of 5 years. There is also a pre-school teacher questionnaire.

4. The parent and teacher Vanderbilt Questionnaires are for those 6 years or older. Please request extra copies of the questionnaires if you would like more than one parent or teacher's observations. These may be given directly to the teacher(s) or according to your school's policy; and may be returned here by mail, fax, or by yourself.

We look forward to helping you and your child with an accurate and scientific evaluation, diagnosis and treatment, much of which is dependent on information from these questionnaires.

ROSS E. WILLIAMS, M.D., F.A.A.P.

Today's Date ____/____/____

Patient's Last Name ______ First Name ______ Nickname ______ Date of Birth ____/____/____ Age ______

Address ______ City ______ State ______ Zip Code ______

Home phone ______ Work phone ______ Cell Phone ______

Sex: M F Marital Status: ______ Email Address: ______

Student Status: ___Full-time ___Part-time Work Status: ___Full-time ___Part-time___Not Employed ___Retired

Patient's Pediatrician or Family Doctor ______

PARENT OR GUARDIAN INFORMATION (if patient is a minor)

Parent / Guardian Last Name ______ First Name ______ Date of Birth ____/____/____ Age ______

Address Same As Above ☐ ______ City ______ State ______ Zip Code ______

Home phone ______ Work phone ______ Cell Phone ______

Sex: M F Marital Status: ______ Email Address: ______

INSURANCE INFORMATION

Primary Insurance Type ______ Subscriber ID # ______ Group # ______

Secondary Insurance Type ______ Subscriber ID # ______ Group # ______

EMERGENCY CONTACT: Name: ______

Relationship to patient ______ Phone # ______

HOW DID YOU HEAR ABOUT OUR OFFICE ? ______

My signature below acknowledges receipt and agreement of my Client Rights, HIPAA Policies and Office Policies.

Signature ______ Print Name ______ Date ____/____/____

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Purpose: Confirms an individual's directive to allow a mutual exchange of protected health information and medical records between multiple parties.

THE INDIVIDUAL (OR REPRESENTATIVE) CONFIRMING AUTHORIZATION

I authorize the use/disclosure of medical records. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the persons or organizations I authorize below are not health plans, healthcare providers or clearing houses subject to federal health information laws, they may then disclose the protected health information and it may no longer be protected by the federal health information laws.

Patient Name: ____ DOB: ____________________

THE ENTITIES BEING AUTHORIZED

Entities below are authorized to both DISCLOSE and RECEIVE: Name of the person(s) or organization(s) for whom you authorize the mutual exchange of protected health information and medical records.

DR. ROSS E. WILLIAMS and

____ FAX: ____________________

____ FAX: ____________________

____ FAX: ____________________

EXPIRATION AND REVOCATION: This authorization will expire :____________________

Right to Revoke: I may revoke this authorization at any time by giving written notice to Dr. Williams. Location of this authorization will NOT affect any action taken prior to receipt of my written notice or revocation.

Signature: ____ Date: ____________________

If authorization is signed by parent/guardian on behalf of the individual, please print the following:

Name: ____ Relationship: ____________________

You are entitled to a copy of this authorization.

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PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Date ____________________

Phone Number ________________

Cell phone Number ______________

Child's Name ____
Last First Middle Nickname

Child's Age ________ Birthdate ______________ Sex ___________ Race ______________

Informant or Parent ____

Relationship to child ____

1. Child's Father _________________________ Child's Mother____________________

   Age _____ Height _______ Weight _____ Age ____ Height _____ Weight ______

   Health _____________________________ Health ___________________________

   Last school grade completed ___________ Last school grade completed ________

2. List the ages, sex, and health of your children, starting with the oldest:

First & Last Name	Birthday	Sex	Health

4. With what doctor was your child's last check-up? ____________________

5. Has your child ever had a convulsion, fit, or spell? Yes No

6. Is your child allergic to any medications? Yes No

   If so, what? ____________________

7. Has your child ever reacted poorly to any immunizations, shots, or medications? Yes No
   If so, what? ____________________

8. Circle any of the following diseases that the child's parents, grandparents, aunts, uncles, Brothers, sisters, or cousins have had, and state who had it.

Diabetes
Thyroid problems
Heart disease
High blood pressure
Kidney or urinary problems
Birth defects
Convulsions
Mental retardation
Allergies
Tics or Tourette's syndrome
ADD/ADHD

Bleeding problems
Anemia
Cancer
Psychiatric problems: depression
bi-polar disorder
schizophrenia
Epilepsy
Eczema
Asthma or bronchitis
Autistic Spectrum disorder
Other ____________________

9. Has your child ever been put in a hospital or had an operation?

Age	Hospital	Illness or Operation

10. Circle any of the following diseases that your child has had.

Ten day measles
Three day measles
Chickenpox
Mumps
Hepatitis

Scarlet fever
Impetigo
Rheumatic fever
Pneumonia
Tuberculosis

Convulsions
Urinary/kidney infection
Meningitis
Whooping Cough
Asthma
Other ____________________

are not always in the same column.

11. While the mother was pregnant with this child, did she have any problems? No Yes
12. Did she have any sugar in the urine? No Yes
13. Did she have any infections? No Yes
14. Did she go to the doctor during her pregnancy? Yes No
15. Was your child born early; how many weeks early? ___________ No Yes
16. Was your child born too late; how many weeks too late? _________ No Yes
17. What was your child's birthweight? ____________ lbs. ________oz
18. Was there any trouble at delivery? No Yes
19. Was there anything wrong with your baby? No Yes
20. Was there any treatment for jaundice? No Yes
21. Did your baby have any trouble in the newborn nursery? No Yes
22. Did your baby come home from the hospital with you? No Yes
23. Has the child's mother had any miscarriages? When? ____________ No Yes
24. Was your baby bottle or breast fed? ____________
25. Were there any serious feeding problems? No Yes
26. Do you think your child is healthy? Yes No
27. Has your child grown too slowly? No Yes
28. Is your child's appetite usually good? Yes No
29. Has your child ever been anemic? No Yes
30. Does your child have any bowel problems, constipation or diarrhea? No Yes
31. Has your child ever:
    - been seriously burned? No Yes
    - taken any medicines or poisons accidentally? No Yes
    - broken any bones? No Yes
    - had a severe head injury or been knocked out? No Yes
    - had any other serious accidents or injuries? No Yes
32. Has your child ever lost any weight? No Yes
33. Has your child ever had asthma or wheezing? No Yes
34. Does the child tend to have a constant cold or stuffy nose? No Yes
35. Does the child have a persistent sore throat or hoarseness? No Yes
36. Has the child had an ear infection more than two times? No Yes
37. Has the child ever had a draining or runny ear? No Yes
38. Has the child ever had frequent nosebleeds for no apparent reason? No Yes
39. Does your child hear well? Yes No
40. Does your child see well? Yes No
41. Do your child's eyes ever cross (lazy eye ?) No Yes

43. Has your child ever had red, painful, or swollen joints? No Yes
44. Has your child ever had to urinate more frequently than usual? No Yes
45. Has your child ever had pain while urinating or blood in the urine? No Yes
46. Has your child ever had an elevated lead test? No Yes
47. Has your child ever eaten paint, clay, or other unusual substances? No Yes
48. Does your child have trouble with his/her teeth? No Yes
49. When did your child last see a dentist? Date____________________

    Dentist's Name: ______________________________

50. Does your child have a heart murmur or anything wrong with his/her heart? No Yes
51. Does your child often wet the bed? No Yes
52. Does your child often wet or soil his/her clothes? No Yes
53. Has your child ever had serious reactions to bee or wasp stings? No Yes
54. Does your child have trouble with his feet or legs? No Yes
55. Is your child usually happy? Yes No
56. Does your child get along well with other children? Yes No
57. Could your child sit up by himself at 9 months? Yes No
58. Could your child walk alone by 15 months? Yes No
59. Is your child clumsy with his/her hands? No Yes
60. Which hand does your child use to eat with? R L
61. Which hand does your child use to throw a ball? R L
62. Can your child ride a tricycle? Yes No
63. Can your child dress himself/herself? Yes No
64. Could your child say understandable words (other than mama or dada) by 19 months? Yes No
65. Could your child put words together in sentences by age 3 years? Yes No
66. Does your child understand what people say to him/her? Yes No
67. Has your child learned any nursery rhymes, Bible verses, or TV commercials? Yes No
68. Do you think your child's play and thinking are as good as most children his/her age? Yes No
69. Has your child ever been exposed to anyone with tuberculosis? No Yes
70. Has your child been skin tested for tuberculosis? Yes No
71. Was the skin test negative? Yes No
72. If your child is attending school, which school does he/she attend?

    ____

73. Does your child enjoy school? Yes No
74. Do you think your child's school work should be better? Yes No

76. Has your child ever had to repeat a grade? No Yes

77. Is your child in a special class or getting special help? No Yes

78. Has the school ever recommended intelligence tests or a special class for your child? No Yes

79. Is your child's behavior a problem in school? No Yes

80. Do you have pets? If so, list them ______________________

81. Has your child had problems with any of the following? (Please circle)

Won't mind	Thumbsucking	Lying
Clumsiness	Can't stick to one thing long enough	Stealing
Too active	Poor speech	Starting fires
Excessive tiredness	Stuttering	Too shy
Easily upset	Breath holding	Irregular bedtime
Bad temper	Cries too much	Doesn't sleep in own bed
High strung or nervous	Fights too much	Picky eater
Trouble sleeping	Clings to mother	Clings to friends
Frequent headaches	Nightmares	Can't toilet train
Nail biting	Breaks things on purpose	

82. Was this child adopted? Yes No

83. This child is/was a foster child? Yes No

84. Parents are ☐ separated or ☐ divorced

☐ one or ☐ both parent(s) are deceased

If so, child lives mainly with (check one or more)

☐ Mother ☐ Stepmother ☐ Grandparents ☐ Father ☐ Stepfather ☐ Other ____________

85. Any significant family stressors affecting your child?

☐ Marital problems

☐ Losses; grandparent or others; pet, friends, etc.

☐ Financial problems

☐ Recent moves or changes in schools

Comments: (If you need additional space, use reverse side. Please describe any special problems or concerns you may have.)

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
Total number of questions scored "2" or "3" in question #'s 1-9: ______				
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/her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 10-18: ______				
Total Symptom Score for question #'s 1-18: ______				
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
26. Is spiteful and wants to get even	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 19-26: ______				
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 (i.e., "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

-Please Turn Over-

NICHQ

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Today's date: __________ Child's Name: ______________________ Date of Birth: ____________ Parent's Name: ________________

	Never	Occasionally	Often	Very Often
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
Total number of questions scored "2" or "3" in question #'s 27-40: ________				

	Never	Occasionally	Often	Very Often
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/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
Total number of questions scored "2" or "3" in question #'s 41-47: ________				

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 (e.g., teams)	1	2	3	4	5
Total number of questions scored "4" or "5" in question #'s 48-55: ________					
Average Performance Score: ________					

COMMENTS:

NICHQ

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NICHQ Vanderbilt ASSESSMENT Scale –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. Fails to give attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by extraneous stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 1-9: ________				
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected.	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor."	0	1	2	3
15. Talks excessively.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting in line.	0	1	2	3
18. Interrupts or intrudes on others (e.g., butts into conversations/ games).	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 10-18: ________				
Total Symptom Score for question #'s 1-18: ________				
19. Loses temper.	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules.	0	1	2	3
21. Is angry or resentful.	0	1	2	3
22. Is spiteful and vindictive.	0	1	2	3
23. Bullies, threatens, or intimidates others.	0	1	2	3
24. Initiates physical fights.	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (e.g., "cons" others)	0	1	2	3
26. Is physically cruel to people.	0	1	2	3
27. Has stolen items of nontrivial value.	0	1	2	3
28. Deliberately destroys others' property.	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 19-28: ________				

-Please Turn Over-

NICHQ Vanderbilt ASSESSMENT Scale –TEACHER Informant

Teacher's Name:____________________ Class Time: ________ Class Name/Period: ____________________

Today's Date: __________ Child's Name: ______________________________ Grade Level: __________________

	Never	Occasionally	Often	Very Often
29. Is fearful, anxious, or worried.	0	1	2	3
30. Is self-conscious or easily embarrassed.	0	1	2	3
31. Is afraid to try new things for fear of making mistakes.	0	1	2	3
32. Feels worthless or inferior.	0	1	2	3
33. Blames self for problems; feels guilty.	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her."	0	1	2	3
35. Is sad, unhappy, or depressed.	0	1	2	3
Total number of questions scored "2" or "3" in question #'s 29-35: ________				

PERFORMANCE *Academic Performance*	Excellent	Above Average	Average	Somewhat of A Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written Expression	1	2	3	4	5
Classroom Behavioral Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of A Problem**	**Problematic**
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5
Total number of questions scored "4" or "5" in question #'s 36-43: ________					
Average Performance Score: ________					

COMMENTS:

PLEASE RETURN THIS FORM TO:____

MAILING ADDRESS:____

____

FAX NUMBER:____