

# **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 \_\_\_\_/\_\_\_\_/\_\_\_\_

# ROSS E. WILLIAMS, M.D.

1121 MEDICAL CENTER DRIVE – WILMINGTON, NC 28401

Phone: 910-763-8134 Fax: 910-763-3311

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.



# 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

### ADOLESCENT HEALTH HISTORY QUESTIONNAIRE

Date \_\_\_\_\_

Phone Number \_\_\_\_\_

Cell phone Number \_\_\_\_\_

Completed by: \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle Nickname

Patient's Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Patient's Address \_\_\_\_\_

Parent's Address (If different from patient) \_\_\_\_\_

Phone \_\_\_\_\_

1. Patient's Father \_\_\_\_\_ Patient'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 brothers and sisters starting with the oldest:

First & Last Name	Birthday	Sex	Health

3. When and where was your last routine check-up? \_\_\_\_\_

4. With what doctor was your last check-up? \_\_\_\_\_



5. Have you ever had a convulsion, fit, or spell? Yes No
6. Are you allergic to any medications? Yes No
- If so, what? \_\_\_\_\_

7. Have you ever reacted poorly to any immunizations, shots, or medications? Yes No
- If so, what? \_\_\_\_\_

8. Circle any of the following diseases that your parents, grandparents, aunts, uncles, brothers, sisters, or cousins have had, and state who had it.

Diabetes	Bleeding problems
Thyroid problems	Anemia
Heart disease	Cancer
High blood pressure	Psychiatric problems: depression
Kidney or urinary problems	bi-polar disorder
Birth defects	schizophrenia
Convulsions	Epilepsy
Mental retardation	Eczema
Allergies	Asthma or bronchitis
Tics or Tourette's syndrome	Autistic Spectrum disorder
ADD/ADHD	Other _____

9. Have you ever been put in a hospital or had an operation?

Age	Hospital	Illness or Operation

10. Circle any of the following diseases that you have had.

Ten day measles	Scarlet fever	Convulsions
Three day measles	Impetigo	Urinary/kidney infection
Chickenpox	Rheumatic fever	Meningitis
Mumps	Pneumonia	Whooping Cough
Hepatitis	Tuberculosis	Asthma
		Other _____

The following questions only require that you circle Yes or No. Please note, the Yes and No are not always in the same column.



- |   |     |     |
|---|-----|-----|
| 11. While your mother was pregnant with you, did she have any problems? | No  | Yes |
| If yes, please list _____   |     |     |
| 12. How much did you weigh when you were born? _____ lbs. _____ oz.     |     |     |
| 13. Did you have any trouble in the newborn nursery?                    | Yes | No  |
| 14. Do you think you are healthy?                                       | Yes | No  |
| 15. Have you grown too slowly?  | Yes | No  |
| 16. Is your appetite usually good?                                      | No  | Yes |
| 17. Have you ever been anemic?  | No  | Yes |
| 18. Do you have any bowel problems, constipation, or diarrhea?          | No  | Yes |
| 19. Have you ever:  |     |     |
| been seriously burned?  | No  | Yes |
| taken any medicines or poisons accidentally or on purpose?              | 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 |
| 20. Have you ever lost any weight?                                      | No  | Yes |
| 21. Have you ever had asthma or wheezing?                               | No  | Yes |
| 22. Do you tend to have a stuffy nose or constant cold?                 | No  | Yes |
| 23. Do you often have a sore throat or hoarseness?                      | No  | Yes |
| 24. Have you had an ear infection more than two times?                  | No  | Yes |
| 25. Have you ever had a draining or runny ear?                          | No  | Yes |
| 26. Have you ever had frequent nosebleeds for no apparent reason?       | No  | Yes |
| 27. Do you hear well?   | Yes | No  |
| 28. Do you see well?  | Yes | No  |
| 29. Do your eyes ever cross?  | No  | Yes |
| 30. Are you either wearing or supposed to be wearing glasses?           | No  | Yes |
| 31. Have you ever had red, painful, or swollen joints?                  | No  | Yes |
| 32. Have you ever had to urinate more frequently than usual?            | No  | Yes |
| 33. Have you ever had pain while urinating or blood in the urine?       | No  | Yes |
| 34. Have you ever had an elevated lead test?                            | No  | Yes |
| 35. Do you have trouble with your teeth?                                | No  | Yes |
| 36. When did you last see a dentist? Date _____                         |     |     |
| Dentist's Name: _____   |     |     |
| 37. Do you have a heart murmur or anything wrong with your heart?       | No  | Yes |
| 38. Do you wet the bed?   | No  | Yes |
| 39. Do you wet or soil your clothes?                                    | No  | Yes |
| 40. Have you ever had serious reactions to bee or wasp stings?          | No  | Yes |
| 41. Do you have trouble with your feet or legs?                         | No  | Yes |



42. Are you usually happy? Yes No
43. Do you get along well with others? Yes No
44. Have you ever been exposed to anyone with tuberculosis? No Yes
45. Have you ever been skin tested for tuberculosis? Yes No
46. Was the skin test negative? Yes No
47. If you are attending school, which school do you attend?

48. Do you enjoy school? Yes No
49. Do you think your school work should be better? Yes No
50. Do the teachers think your school work should be better? Yes No
51. Have you ever had to repeat a grade? No Yes
52. Are you in a special class or getting special help? No Yes
53. Has the school ever recommended intelligence tests or a special class for you? No Yes
54. Is your behavior a problem in school? No Yes
55. Do you have pets? If so, list them \_\_\_\_\_
56. Are you employed? If so, where \_\_\_\_\_  
Hours per week \_\_\_\_\_
57. Are you single, married, divorced, or separated? (Please circle)  
How long? \_\_\_\_\_ Spouse's name \_\_\_\_\_
58. Do you have children? If so, please list:

First & Last Name	Birthday	Health

59. Have you ever had problems with any of the following? (Please circle)

Clumsiness	Thumbsucking	Stealing
Too active	Can't stick to one thing long enough	Starting fires
Excessive tiredness	Poor speech	Too shy
Easily upset	Menstruation problems	Probation
Bad temper	Stuttering	Picky eater
High strung or nervous	Cry too much	Smoking
Trouble sleeping	Fight too much	Drinking



Frequent headaches

Legal problems

Drugs

Nightmares

Suicide

Nail biting

Lying

Breaking things on purpose

60. Were you adopted?

Yes No

61. Were/Are you a foster child?

Yes No

62. Parents are ☐ separated or ☐ divorced

☐ one or ☐ both parent(s) are deceased

If so, you live mainly with ( check one or more)

☐ Mother ☐ Stepmother ☐ Grandparents ☐ Father ☐ Stepfather ☐ Other \_\_\_\_\_

63. Any significant family stressors affecting you?

☐ Parent's marital problems

☐ Problems with brothers, sisters, stepbrothers, stepsisters, stepparent

☐ 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.)



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-**



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: _____				
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 Vanderbilt ASSESSMENT Scale –TEACHER Informant

Page 1

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

Page 2

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: \_\_\_\_\_