HMG Pediatrics at Medical Plaza
105 W Stone Drive, Suite 2A
Kingsport, TN 37660
(423) 230-2430

Attention Deficit Hyperactivity Disorder Assessment

Dear Parent/Guardian,

If you have concerns about behavior, attention, or learning problems, we want you to know that we are here to assist you. In order for us to provide a thorough evaluation, it's important that we gather as much information from you as possible for a proper diagnosis to be made. This includes birth history, family history, school history and data (achievement tests, IQ tests, grades, teacher reports, etc.), and other behavioral history.

Many parents and children seek our help because of poor school performance or behavioral problems at school and home. You may have heard the terms "lazy", "poorly motivated", "learning disabled", "short-fused", "hyperactive", "scatterbrained", or "inattentive" used to describe your child. Many times, learning disabilities masquerade as behavioral or performance problems. Therefore, we will need to get measurements of your child's IQ and scholastic achievement level; discrepancies in these areas are indicative of learning disabilities.

Included in this packet are a number of forms for you and for your child's teacher to complete. Be sure to complete the release form which will allow us to exchange information if needed. Upon review of the completed packet, we will contact you to schedule your first appointment. Typically, your child will need to be seen by the physician at least twice to complete an evaluation and provide a proper diagnosis. We want to be sure to take our time and fully understand the challenges your child is facing.

If you have any questions concerning this assessment, please give us a call at (423) 230-2430. Please note that we require a 48 hour cancellation notice if you must cancel your appointment for any reason.

We look forward to working with you and your child.

Thank you,

HMG Pediatrics at Medical Plaza

Health History

Regular Physician: _____

Referring Physician: _____

Date of last physical exam: _____

Are immunizations up to date? ☐ Yes ☐ No ☐ Not sure

Current medications: _____

Any special diet or vitamins? _____

Any foods that are avoided and why? _____

Any allergies? _____

At any time, has your child had the following?

	Never	Past	Present
Asthma	☐	☐	☐
Allergies	☐	☐	☐
Thyroid Problems	☐	☐	☐
Diabetes	☐	☐	☐
Arthritis or other chronic illness	☐	☐	☐
Febrile seizures	☐	☐	☐
Epilepsy or seizure disorder	☐	☐	☐
Heart or blood pressure problems	☐	☐	☐
High fever (over 104º)	☐	☐	☐
Broken bones	☐	☐	☐
Severe cuts requiring stitches	☐	☐	☐
Head injury with loss of consciousness	☐	☐	☐
Concussion	☐	☐	☐
Lead Poisoning	☐	☐	☐
Surgery	☐	☐	☐
Hospitalization more than overnight	☐	☐	☐
Speech or language problems	☐	☐	☐
Chronic ear infections	☐	☐	☐
Hearing difficulties	☐	☐	☐
Eye or vision difficulties	☐	☐	☐
Fine motor/handwriting problems	☐	☐	☐
Gross motor difficulties, clumsiness	☐	☐	☐
Appetite problems (over/under eating)	☐	☐	☐
Sleep problems (falling/staying asleep)	☐	☐	☐
Wetting problems	☐	☐	☐
Soiling problems	☐	☐	☐

Other health problems, describe: _____

_____

Family Data

Child's Name: _____ Birthday:_____

Adopted? ☐ Yes ☐ No In School? ☐ Yes ☐ No

Name of School: _____ Grade: _____

Special Services? ☐ Yes ☐ No
If yes, please describe:_____

Birth Father's Name: _____Age:_____Level of Education: _____
Occupation: _____ History of learning problems?_____

Birth Mother's Name: _____Age:_____Level of Education: _____
Occupation: _____ History of learning problems?_____
Marital status: ☐ Single ☐ Married ☐Separated ☐Never Married

Step Parent's name: _____Age: _____Level of Education: _____
Occupation: _____

Name and age of people living with the child. Include parents and other children at home and specify if adopted, foster, or half sibling: _____

_____

_____

If not living with both natural parents, describe any visitation, how often, and any behvioral problems before or after the visits: _____

_____

_____

List any problems with any other members in the family: _____

_____

_____

Have there been any recent changes (good or bad) in the child's life or family?

_____

_____

_____

Family Data (continued)

How did you get referred for this evaluation and what problems are you having?

_____

_____

How long have you recognized this difficulty? _____

_____

Is your child having any behavioral problems? _____

Who handles the discipline at home and how is it handled? _____

_____

	Yes	No
Can your child sit and put a puzzle together?	☐	☐
Can your child sit and read a book alone?	☐	☐
Can your child sit and watch a TV program or video?	☐	☐
Does your child fidget a lot with the TV?	☐	☐

Describe your child's behavior during meals? _____

_____

Describe any behavior problems out in the public: _____

_____

Does your child have any routine chores? If so, describe: _____

_____

If asked to do 3 things at once, how many would your child remember? ___actually do?___

How many times has the family moved since your child's birth? _____

How many tmes has the child changed schools? (please list schools and grades attended).

_____

_____

	Yes	No
Has it been suggested that your child repeat a grade?	☐	☐
Has your child repeated any grades and why?	☐	☐

_____

_____

Family Data (continued)

What have you tried in the past to help your child?

_____

_____

	Yes	No
Do you think your child is depressed or sad for days or longer?	☐	☐
Do you think your child is anxious or nervous a lot?	☐	☐

Have you or your child experienced any unusual or traumatic events in your life recently (i.e. death of a loved one, serious illness/injury to self or loved one, loss of employment, trouble with the law, birth of a child, etc.)?

_____

_____

_____

_____

Family History

Are there any relatives with a history of the following?

	Father	Mother	Sibling	Other
Problems with aggressiveness				
Defiance or oppositional behavior as a child	☐	☐	☐	☐
Problems with attention, activity, or impulse control	☐	☐	☐	☐
Learing disabilities	☐	☐	☐	☐
Failed to graduate high school	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐
Psychosis or schizophrenia	☐	☐	☐	☐
Bipolar disease (manic depression)	☐	☐	☐	☐
Depression for greater than 1 month	☐	☐	☐	☐
Anxiety disorder	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐
Tics or Tourettes Syndrome	☐	☐	☐	☐
Alcohol abuse/Alcoholism	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐
Eating disorder (anorexia, bulimia, nervosa)	☐	☐	☐	☐
Antisocial behavior (assault, theft, etc.)	☐	☐	☐	☐
Arrests	☐	☐	☐	☐
Physical abuse	☐	☐	☐	☐
Sexual abuse	☐	☐	☐	☐

Are there any problems in the family at this time that are affecting one or more members of the family? (marital, financial, serious illness, etc.)

_____

_____

_____

_____

BIRTH & DEVELOPMENT

PREGNANCY

Was delivery full term, early, or late?_____

	Yes	No
Can your child sit and put a puzzle together?	☐	☐
Can your child sit and read a book alone?	☐	☐

Did mother smoke, take any medications, consume alcohol or drugs during pregnancy?

_____

Any complications during pregnancy (toxemia, eclampsia, infections, etc.)?

_____

LABOR & DELIVERY

Natural, induced or medicated, forceps, C-Section? _____

Birth Weight: _____ Length: _____ Apgars Score:_____

Any health complications after birth? _____

Was oxygen or respirator needed? _____

Was baby alert and responsive? _____

Any jaundice?_____ If yes, what was the treatment? _____

Any congenital problems? _____

If yes, how does it affect your child's life now? Have there been any corrective surgeries in the past? _____

EARLY CHILDHOOD DEVELOPMENT (The first year of life)

	Yes	No		Yes	No
Severe colic	☐	☐	Feeding problems	☐	☐
Sleeping problems	☐	☐	Eating problems	☐	☐
Temper tantrums	☐	☐	Head banging	☐	☐
Rocking behavior	☐	☐	Clumsy	☐	☐
Impulsive	☐	☐	More active than expected?	☐	☐

How old was your child when sitting? _____ Walking alone? _____

Talking? _____Toilet trained? _____

Were there any serious illnessess, hospitalizations, or surgeries? If so, please list approximate dates and ages? _____

_____

Has your child ever had seizures, blackout spells, or seroius head trauma? _____

HOME SITUATIONS QUESTIONNAIRE

Child's Name: _____Date: _____

Name of person completing this form:_____

DOES THIS CHILD PRESENT ANY BEHAVIOR PROBLEMS IN ANY OF THESE SITUATIONS? IF SO, PLEASE INDICATE HOW SEVERE THEY ARE.

	YES	NO	SEVERITY SCALE MILD (1) TO SEVERE (9)
While playing at home	☐	☐	1 2 3 4 5 6 7 8 9
While with other adults	☐	☐	1 2 3 4 5 6 7 8 9
While with other children	☐	☐	1 2 3 4 5 6 7 8 9
Mealtimes	☐	☐	1 2 3 4 5 6 7 8 9
Getting dressed	☐	☐	1 2 3 4 5 6 7 8 9
Washing/Bathing	☐	☐	1 2 3 4 5 6 7 8 9
While you are on the phone	☐	☐	1 2 3 4 5 6 7 8 9
While watching TV	☐	☐	1 2 3 4 5 6 7 8 9
When visitors are in your home	☐	☐	1 2 3 4 5 6 7 8 9
When you are visiting someone	☐	☐	1 2 3 4 5 6 7 8 9
In stores	☐	☐	1 2 3 4 5 6 7 8 9
In churches	☐	☐	1 2 3 4 5 6 7 8 9
In restaurants	☐	☐	1 2 3 4 5 6 7 8 9
Other pulbic places	☐	☐	1 2 3 4 5 6 7 8 9
Doing routine work at home	☐	☐	1 2 3 4 5 6 7 8 9
When asked to do chores	☐	☐	1 2 3 4 5 6 7 8 9
At bedtime	☐	☐	1 2 3 4 5 6 7 8 9
While in the car	☐	☐	1 2 3 4 5 6 7 8 9
While with a babysitter	☐	☐	1 2 3 4 5 6 7 8 9
When father is home	☐	☐	1 2 3 4 5 6 7 8 9
When doing homework	☐	☐	1 2 3 4 5 6 7 8 9

BEHAVIOR HISTORY

For at least the past six months, has your child demonstrated any of these behaviors considerably more frequently than most other children the same age?

Please check all that apply.

_____ Has difficulty remaining seated when required to
_____ Often fidgets with hands or feet or squirms in the seat
_____ Sense of internal restlessness
_____ Has difficulty playing quietly
_____ Often talks excessively
_____ Often shifts from one uncomplicated activity to another
_____ Has difficultly following instructions
_____ Is easily distracted
_____ Often interrups or intrudes on others
_____ Ofttern blurts out answers to questions before completed
_____ Has difficulty waiting in lines or in group situations
_____ Often engages in physically dangerous activities/thrill-seeking
_____ Is often extremely messy or sloppy
_____ Often loses things needed for finishing tasks at home or school
_____ Often does not seem to listen to what is being said
_____ Delays in getting fully dressed
_____ Lingers or delays at mealtime
_____ Slow in getting ready for bed
_____ Gets angry when not getting his/her own way
_____ Cries easily
_____ Is careless with toys, hobbies, and other objects
_____ Engages in excessive imaginary play
_____ Hears voices or noises that are not there
_____ Sees things that other people do not see
_____ Often deliberately does things that annoy people
_____ Often blames others for mistakes
_____ Often lies without thinking of consequences or to cover up mistakes
_____ Diminished pleasure in activities or friends
_____ Suicidal ideation or attempt
_____ Overreacts to touch
_____ Has compulsive rituals
_____ Motor tics
_____ Vocal tics
_____ Has panic attacks
_____ Excessive or inappropriate reaction to change in routine

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
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

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

Revised - 1102

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
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

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

REQUIRED 48 HOUR NOTICE

Please note that we require a 48 hour notice for paperwork and perscription refill requests. These requests are time consuming to complete and last minute phone calls and walk-in requests cannot be honored unless deemed medically necessary by our staff.

In order to provide the necessary attention to patients with scheduled appointments, we ask that you please plan ahead and allow the necessary time for us to process your requests.

We appreciate your cooperation and consideration of other patients and apologize for any inconvenience this may cause.

HMG Pediatrics at Medical Plaza

I have read the above statement and understand as noted by my signature below:

_____ _____

Signature Date

BEHAVIORAL HEALTH APPOINTMENT CANCELLATION & NO SHOW POLICY

HMG Pediatrics at Medical Plaza requires a 48 hour cancellation notice for all behavioral health appointments. Because these appointments are typically longer time slots to address very complex and often chronic concerns, providing us at least 48 hours notice of any cancellation allows our team members the time to reach other patients who might be able to utilize your appointment time.

Please note that Holston Medical Group will bill the responsible party a fee of $87.00 for missed behavioral health appointments without the necessary 48 hour notice prior to the scheduled appointment time.

I have read the above statement and understand the policy as stated. I have also been given the opportunity to ask any questions and voice any concerns. My cosent to abide by this policy is noted by my signature below.

Failure to consent to the above policy will require that you find another provider to meet your child's behavioral needs.

_____ _____

Responsible Party Date

_____ _____

Witness Date

EDUCATIONAL HISTORY

NAME OF SCHOOL: _____

Is your child currently having trouble in school? YES / NO

Learning Problems? YES / NO Behavior Problems? YES / NO Social Problems? YES / NO

What were your child's most recent report card grades? _____

Last year's report card grades?_____

Is your child now or has he/she ever been in special ed classes or resource room? YES / NO

Has your child repeated any grades or been recommended to repeat a grade? YES / NO

If so, what reason did the school provide? _____

Describe any problems your child had in daycare or nursery school: _____

Did your child enjoy the last full year of school? YES / NO

What was your child's strongest area in school? _____

What was your child's weakest area in school? _____

What is your child's most effective way of studying/learning style? _____

How does your child's current teacher describe your child? _____

Have other year's teachers had similar or different opinions? _____

Do you agree with this evaluation of your child? YES / NO

Has your child received a psychological or educational evaluation through the school? YES / NO

When?_____ (Please bring a copy with you to your appointment with us)

Summarize results: _____

Has your child had any mental health treatment? YES / NO

If yes, when and how helpful was it? _____

How many caffeinated drinks does your child consume in a day? (tea, coffee, soda) _____

Is your child now or in the past been cruel to or hurt animals? YES / NO

Has your child ever set fires? YES / NO

Has your child ever tried to hurt any family member? YES / NO Anyone outside the family? YES / NO

Has your child ever tried to hurt themselves or commit suicide? YES / NO

Is your child currently thinking of suicide? YES / NO

Has your child ever gained or lost a lot of weight in a short period of time? YES / NO

Do you have any concerns about your child's diet/weight?_____

Does your child have trouble sleeping? YES / NO What do you do? _____

Does your child play as much or the same as other children the same age? YES / NO

Does your child smile and laugh as much as he/she used to? YES / NO

Does your child seem depressed? YES / NO

***Please use the back of this page to describe your child's personsality, favorite/least favorite things, hopes and fears, hobbies, etc. in order for us to get to know him/her better.*

HMG Pediatrics Release Form
Behavioral Health Treatment

My child's teacher, _____, as well as the school principal and counselor at _____ school has my permission to release academic, behavioral, and social and emotional information on my child to HMG Pediatrics. In addition, I also allow permission for the teacher, principal, and counselor to discuss their difficulties and/or progress with my child with HMG Pediatrics in order to address my child's behavioral health needs. This permission to contact the school will continue unless a written instruction to the contrary is received by the physician's office. I understand that my child cannot be evaluated without this consent.

_____ _____

Parent/Responsible Party Signature Date

_____

Parent/Responsible Party Printed Name

Address: _____

Telephone #: _____

School Name: _____

School Address: _____

School Year: _____

School Telephone: _____